

Gynaecology

The Treatment of Functional Uterine Bleeding

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An alteration in the normal pattern of menstruation is a common reason for a woman to seek medical advice. In some cases the explanation of the trouble is disease of the uterus or adnexa which can be found by careful pelvic examination. It is safe to say, however, that in the majority of women who present themselves with this complaint examination reveals no change in the pelvic organs to account for the symptoms. The practitioner may feel baffled by the problem confronting him in these patients, or may even have a sense of grievance that there is no indication to be found for which he can offer a prompt and definite cure. But modern therapy can do much for these women; the day is past when one can dismiss them with a prescription for ergot or calcium. Nor is it enough simply to order one of the potent oral oestrogens which are advertised so widely, to be taken as regularly as iron pills for anaemia, in the pious hope that because it is a female sex hormone it should surely accomplish something for the sufferer. The following remarks are designed to offer guidance in the rational management of these troublesome cases.

The diagnosis of functional disorder must be made only after a careful examination to exclude organic disease. Even in teen-aged girls, vulvar and rectal examination should not be omitted, to determine whether there is normal uterine development, a perforate hymen, and no adnexal tumour. In some instances cervical biopsy and even curettage will be required before the case can safely be labelled functional. Furthermore, as the patient returns for supervision of treatment and to report progress, one must not fail to re-examine her from time to time. The case of amenorrhoea may turn out to be one of progressively enlarging abdominal tumour where auscultation may reveal foetal heart sounds, while the resistant case of menorrhagia may, in time, be found to have a fibroid polypus presenting at the external os. The case of irregular bleeding attributed to such circumstances as the husband's loss of employment or the sudden death of an aunt may well be due to a tubal pregnancy.

Functional bleeding can be and sometimes is, alarmingly profuse, suggesting an incomplete abortion, especially if it is due to metropathia haemorrhagica, where there is a long-continued oestrogen effect on the endometrium with failure

of corpus luteum development. These cases not infrequently give a history of two or three months amenorrhoea prior to the commencement of the haemorrhage.

A patient, Mrs. R., aged 36, was admitted to hospital with a history of profuse bleeding with the passage of many large clots, of five days duration. The haemoglobin was 41 per cent. On admission she was found to be saturating a vulvar pad every hour. The cervix was closed and healthy, the corpus was irregularly enlarged, and a diagnosis of multiple myomata was made. After several transfusions, by which the haemoglobin was raised to 67 per cent, a curettage was performed to exclude a disturbance of an early pregnancy but only normal endometrium was recorded. Total hysterectomy was carried out. The uterus contained two subserous fibroids which by no means encroached on the uterine cavity and which could not account for the profuse bleeding. The uterine cavity showed no lesion and the endometrium was normal on histological examination.

In reaching the conclusion that abnormal bleeding is functional in type, a careful and accurate history is essential. One should insist on the actual dates of all episodes of bleeding, and if the patient cannot furnish them the diagnosis should be deferred until she returns a month or so later with a written record of events in the interval. This may sometimes show that there is no real abnormality. A woman not infrequently presents herself with the complaint that she has menstruated twice in a month, and she is in great distress as a result. A little questioning as to details may disclose that the penultimate period commenced at the beginning of the month and the last one at the close of the same month so that the actual cycle was close to twenty-eight days in duration; what happened was merely that the days of onset of two successive periods fell within the same calendar month. This may seem too absurd to merit mention but quite often mistakes are made through accepting without questioning the patient's own interpretation of events. Or a young woman may declare that her periods are coming every two weeks when insistence on particulars elicits the history of a fortnight's clear interval with a flow of a week's duration, i.e., the cycle is twenty-one days, which still falls within normal limits.

Functional bleeding tends to occur in a regular pattern. There may be intermenstrual bleeding, but if it occurs regularly, at a constant time after the completion of, or prior to the regular monthly flow, it is unlikely to be due to organic disease.

Bleeding which is completely irregular should always be considered due to an organic cause, and if clinical examination (with close attention to visual inspection of the cervix) is negative, a curettage should be advised. This applies, naturally, especially to women over forty years of age. The cause need not be malignancy; endometrial polypi are of commoner occurrence than is usually supposed and their removal by curettage is usually all that is necessary.

In a case of profuse functional bleeding, where prompt cessation of the haemorrhage is most desirable, the most effective agent is some form of oestrogen. This can be given by mouth, at short intervals and in large dosage, e.g., stilboestrol 5 mg. every four hours. This is continued until the bleeding stops, which is usually within thirty-six hours. Often it abates even sooner than this. Afterwards a maintenance dose of 5 mg. once or twice daily is given for a week or ten days and this will be followed by withdrawal bleeding of reasonable amount.

Stilboestrol often causes nausea and vomiting so an alternative preparation is sometimes preferable, viz., ethinyl oestradiol, which is approximately twenty times as potent as stilboestrol. It is issued in 0.05 mg. and 0.5 mg. tablets, equivalent to 1 and 10 mg. stilboestrol respectively.

The explanation of the action of oestrogens to check functional bleeding is largely hypothetical, but the hypothesis is a valuable one, for it can be applied to other problems of disordered menstrual function, as will be mentioned later, and it works in practice. It has been well described by Bishop¹. It is supposed that there are three levels of effective oestrogen concentration as far as uterine haemorrhage is concerned. An oestrogen level below the bleeding threshold will give rise to "sub-threshold amenorrhoea." A level above the threshold will also give rise to amenorrhoea, but of the "super-threshold" type. A drop in this level to below the bleeding threshold will induce bleeding, the "oestrogen-withdrawal bleeding" which follows a course of oestrogen in cases of amenorrhoea, and which probably is responsible for normal menstruation. So long as the oestrogen concentration remains within the bleeding threshold, constant or intermittent bleeding takes place. To stop the bleeding the effective concentration of oestrogen must be either raised or lowered. It may be raised by giving more oestrogen, lowered by giving androgen or by giving progesterone which renders the uterus less sensitive to oestrogen.

Androgen, in the form of testosterone propionate, 25 mg. once or twice daily can be given, but its action is less certain and is definitely less rapid than that of oestrogen. Progesterone, on theoretical grounds, should be effective but in practice it has been very disappointing in this type of case.

Typical of these cases was Mrs. B., aged 40, para 1, gravida 1. She had menstruated very heavily

for eight days, help was sought after she had fainted and fallen in her home. She was admitted to hospital, when her haemoglobin was found to be 40 per cent; she appeared quite blanched. Stilboestrol 5 mg. was given four-hourly throughout the twenty-four hours and at the end of thirty-six hours the bleeding had stopped completely. Pelvic examination revealed no abnormality of cervix, corpus uteri or adnexa. Transfusions were given to bring the haemoglobin to 70 per cent and the patient was discharged from hospital four days after admission on a maintenance dose of stilboestrol 5 mg. twice daily. She remained perfectly well afterwards. On the twenty-first day after its first administration the stilboestrol was discontinued and as an added precaution against a repetition of the menorrhagia, a course of progesterone was given to produce a normal progestational type of endometrium.

A common type of case seeking relief is one where the periods are regular in occurrence, normal or prolonged in duration, but with an excessive flow, sufficient to interfere with the woman's employment or even her domestic activities. This state of affairs is seen in women of all ages from the menarche to the menopause. As always, the greatest care must be taken to exclude organic disease, but if everything is apparently normal on pelvic examination, what measures are available to afford relief?

If there is any degree of anaemia, as is not infrequently the case, iron must be prescribed and in a few instances it alone seems to have a beneficial effect on the menorrhagia. Thyroid has been used empirically for many years, regardless of the basal metabolic rate, but its efficacy is very doubtful unless there is obvious hypothyroidism. Probably the most useful agents are the androgens. On the assumption that the immoderate bleeding is due to an excessive oestrogen secretion, androgens are given for their oestrogen-attenuating action. While testosterone propionate can be given by injection, comparable results are obtained with the oral preparation, methyl testosterone, especially if the method of sublingual absorption is used. Initially 10 mg. daily throughout the intermenstruum is the dose prescribed and the patient is advised to place the tablet under the tongue or between the gum and the cheek, preferably on going to bed so that she is not inclined to swallow, thus permitting the active principle to be absorbed from the buccal mucous membrane. Too much should not be expected after the first month's treatment, but if definite benefit is noted after two months the dose can be reduced, the patient taking the tablet for only ten or twelve days premenstrually. After four or five months the tablets should be discontinued for a time. Masculinizing effects are practically never seen with the use of this dosage scheme, though some patients develop facial pimples during treatment. These disappear

when the androgen is discontinued. Caution must be exercised, however, when administering this treatment to young girls.

Miss H., aged 17, had consulted a physician a few months before because of facial acne and methyl testosterone linguets had been prescribed. The skin blemishes cleared promptly and the patient was so impressed that she had her prescription repeatedly refilled and took 10 mg. twice daily for about three months. She was referred because her periods had ceased, a growth of dark hair had appeared on the upper lip and the patient's voice had undergone a very noticeable change — it had become deeper and had lost all its timbre, being flat and monotonous. It is well recognized that androgens given to women increase the length of the vocal cords and sometimes this particular effect does not regress when the hormone is discontinued.

Satisfactory improvement can be expected in about fifty per cent of cases of uncomplicated menorrhagia by the use of testosterone. If it fails, the time-honoured curettage is not to be despised, despite the difficulty in explaining why it should be of benefit. Moreover, it may disclose the presence of a previously undetected intra-uterine lesion.

A remedy only recently introduced for use in these cases is toluidine blue 0 (a mixture of the chloride and sulfate salts is available under the name of Blutene). This is an anti-haemorrhagic agent and is used on the supposition that some cases of menorrhagia are due to an elevation of heparin-like substances in the blood. A dose of 100 mg. is given twice or thrice daily for four or five days before the expected date of onset of menstruation. Occasionally nausea and dysuria occur during the administration of the drug but these effects are less likely to be troublesome if a high fluid intake is maintained. Experience of this agent is limited but definite benefit has followed its use in some cases. It is certainly worthy of trial.

If examination by the pathologist of the tissue recovered at curettage establishes a diagnosis of metropathia haemorrhagica, i.e., a pronounced oestrogen effect with no evidence of progestational or secretory changes in the endometrium, the following scheme should be used to bring about regular periods of normal amount: Progesterone, 20 mg. is given intramuscularly on alternative days for four doses, or oral progesterone (ethisterone) 30 mg. daily for a week. This is followed soon afterwards by progesterone-withdrawal bleeding. Commencing four weeks from the beginning of the course, the same dose is repeated. In this way a four-week cycle of bleeding from a secretory endometrium is produced. Troublesome adolescent bleeding is usually of this type and responds to the above scheme of treatment.

When a thorough trial of the above measures

has resulted in failure to ameliorate the patient's symptoms, serious consideration must be given to more radical measures, to terminate menstruation altogether. Naturally, before reaching such a decision one must take into account the woman's age and whether any additions to her family are desired or contemplated. The tendency at the present time is to elect surgery for these patients rather than any form of radiation. By performing hysterectomy the patient's ovaries are conserved and she is not thrust abruptly into the menopause; further, if subsequently oestrogen therapy for the relief of menopausal symptoms is thought advisable, there is no danger of producing uterine bleeding. Often a troublesome cervical discharge is simultaneously dealt with. Some of one's most grateful patients are those who, after several years of chronic ill-health, with enforced days of rest each month, a burden of expense for medical attention and drugs, and unable to discharge satisfactorily their domestic duties, have finally submitted to hysterectomy and have been relieved of the prospect of ever-recurring flooding and restored to a life of happy usefulness.

The opposite condition of hypomenorrhoea is encountered from time to time. To many women the fact that their periods are shorter or scantier than those of the majority of their sex constitutes a cause for much anxiety. One can reassure them with complete confidence, and even congratulate them because their periods are so much less an annoyance than they are to most girls. It is sometimes difficult to convince the patient that this is so — she plaintively insists that she is sure she would feel so much better "if she could just have a real proper clean-out." Endometrial biopsy just before a period is expected practically always shows a normally developed endometrium and fertility is therefore not affected. A simple explanation of the significance of menstruation is called for in these patients.

A type of case commonly seen is that of the young woman whose periods are occurring too frequently, as often as every two weeks, so that if the duration of flow is seven days, there is a clear interval of only a week. One should inquire whether the periods are all the same in amount or duration or if the alternate ones are brief and scanty. The latter history indicates that the patient is probably interpreting as a menstrual period what actually represents ovulation bleeding. But if true menstruation is taking place at intervals much shorter than normal, the cycle can be lengthened by giving oestrogens post-menstrually for fifteen to eighteen days and thereby maintaining the blood oestrogens level above the bleeding threshold for a normal length of time. Withdrawal bleeding will follow a few days after discontinuing the tablets. After two or three months the normal menstrual pattern will be likely to continue unaided.

Ovulation bleeding is seldom profuse or prolonged. The diagnosis is easily made if one insists upon a truly accurate history. The bleeding occurs at a fairly fixed interval prior to the onset of the ensuing period. Occasionally there is a certain amount of associated pain — mittelschmerz. Patients do not usually require treatment. They are satisfied when the physiological nature of the bleeding is explained. It does not necessarily occur every month but can start or stop at any age. If it is really troublesome it can be checked by giving progesterone, 20 mg. daily sublingually for four or five days, starting a day or two before the calculated date of ovulation.

Many cases are seen of premenstrual spotting or scanty bleeding, lasting for several days before the establishment of the normal menstrual flow. Women with this complaint find it truly an annoyance, for it means that they have to wear some form of protection for as long as two weeks out of each month. It is due to irregular shedding of the endometrium and would appear to result from inadequate progesterone formation. It can generally be controlled by the administration of progesterone in moderate doses (the oral form, 10 mg. once or twice daily) for a week premenstrually.

Treatment of all these various types of functional bleeding requires patience. One should

never promise an immediate cure but should impress upon the patient the necessity of continued supervision for some months. Often the dosage of whatever agent one is using will have to be modified, or the timing of its administration must be changed. One must be resigned to a "cure rate" well below one hundred per cent and some patients, in the end, will have to submit to the crude solution of major surgery to obtain relief. However, even these will not be able to reproach their doctor for having performed an unnecessary operation if he has first given a thorough and rational trial of some of the powerful hormone agents available for clinical use at the present time. And there will be many women who can be carried along in reasonable comfort and good health until pregnancy or the menopause imposes a term on their troublesome bleeding. Moreover, it is true that a form of treatment which confers benefit need not be continued indefinitely as a replacement therapy, comparable to insulin in diabetes. Once a patient is brought into a normal pattern of menstruation for a few months she is likely to continue in it after her endocrine therapy has been discontinued. This is one of the gratifying aspects of conservative management of these cases of abnormal menstrual bleeding.

References

1. Bishop, P. M. F.: *Canad. M.A.J.*, 57: 353, 1947.

Cancer

Recent Methods in Cancer Therapy At Memorial Center, New York

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It is with definite purpose that we title this talk "Recent Methods" instead of "Recent Advances". Memorial Center is forever seeking better treatment methods and some prove valueless and are discarded.

Memorial Center for Cancer and Allied Diseases began in the 19th Century in New York as one of the few hospitals specifically for cancer patients. Many General hospitals of that era did not want such patients, especially those with advanced disease. Over the years, Memorial grew, and due in large part to the work of the late James Ewing in Pathology, and the devoted services of a small group of clinicians, it became one of the world's leading cancer centers.

In the past fifteen years a tremendous expansion has occurred. Radical surgery, high voltage therapy, isotope therapy, virus work, and chemotherapy, are all vigorously pursued. A large re-

search program was developed and through the generosity of the General Motors and many private benefactors, a splendid laboratory with special equipment was provided. This is the Sloan Kettering Institute for Cancer Research, which is staffed with scientists of many disciplines. There are chemists, biologists, physicists, pharmacologists, electron microscopists, physiologists, pathologists, and so on; all loosely grouped under the title "long hairs". Other units in the Center include the Strang Cancer Detection Clinic, the Tower Building Out-Patient Clinic, and the James Ewing Hospital, and the Memorial Hospital itself; these latter staffed by clinicians like ourselves, known as "short hairs".

This evening I wish to mention some aspects of radical surgery, radiation therapy, hormone therapy, and chemotherapy.

As regards radical surgery, an aggressive program has been carried forward in all anatomic sites attempting to develop "en bloc" operations to encompass primary tumors and their regional nodes. Dr. Hayes Martin and his team in the Head and Neck Service had been impressed and depressed with the poor world-wide results in oral, pharyngeal, and laryngeal cancers as treated by external radiation and radium techniques. For example, up

to 1944, reports from England (Cade); Scotland (McWhirter); Sweden (Jacobson); Norway (Renmaes) gave 0 to 10% five year "cures" of pharyngeal or extrinsic laryngeal cancer. Up to 1950, further figures from British, French, and Scandinavian centers reported 3% to 14% five year "cures" of such lesions by radiotherapy. These data indicated surgical measures should be re-investigated. Operations for oral, pharyngeal, and laryngeal tumors and involved neck nodes were described and done over fifty years ago by such men as Kocher and Butlin. Infection, slough, haemorrhage, fistulae, and death caused these operations to be abandoned. Today, we are able to carry out such procedures on the aged and infirm. In Memorial Hospital last year, addressing the Fellowship Group, Dr. Charles Harrold was able to report on 382 patients having had combined "en bloc" excisions of intra-oral, pharyngeal, or laryngeal cancers with unilateral or bilateral neck dissections. The operative mortality was 2.7%. The three year "cure" was 38.9%, the five year "cure" rate was 34.6%. At this point, I wish to re-emphasize that many patients are still treated primarily by radiation. Most local recurrences are treated by radiation, small field, high dosage, external radiation, together with interstitial radon. Cases in which surgery can not encompass disease and cases in which surgery will cause an unacceptable deformity are treated by radiation.

On the subject of breast cancer you may be familiar with the British work on the internal mammary nodes. The Handleys, father and son, have investigated the incidence of such metastases. Dr. Jerome Urban at Memorial Hospital has followed through in this regard and he and his residents have done more than one hundred "chest wall" operations. In this procedure, the Halsted operation is extended to include the removal of a rectangle of anterior chest wall, together with the underlying internal mammary vessels and nodes. The operative mortality is under 1%. The long term results are not known as yet. The immediate results of this project are definite—half of the patients with medially situated breast cancers have involved internal mammary nodes. Whether or not Urban's operation becomes widely accepted, at least one can no longer ignore the internal mammary nodes. We must excise or radiate this area in patients with breast cancers so situated.

The next anatomical site I shall discuss is the cervix uteri. Since the late 1930's, when external radiation was added to radium inserts to achieve a uniform tumor dose throughout the pelvis, "cure" rates have risen little. In Britain, France, Denmark, and America, five year "cure" rates have levelled off at about 45%. Truelsen of Copenhagen, reported an overall rate of 45%, ranging from 70% in Stage 1 to 11% in Stage 4. This apparent lack of progress prompted many men to re-investigate surgical

treatment. In earlier years, Wertheim had had a surgical mortality of 15% and in most centers, radium treatment with its 2% mortality became standard.

Radical pelvic surgery has now been done by Dr. Meigs in Boston, Dr. Brunschwig in New York, and many other men, including Dr. Appleby in Vancouver. The procedures include the inadequate Wertheim operation, panhysterectomy and pelvic node dissection, anterior or partial pelvic exenteration, and total pelvic exenteration. Meigs found 18% of League of Nations Stage 1 cervix cancer patients proved to have involved nodes. This, in itself, might be considered an indication for surgical, rather than radiation therapy. The value and place of surgical treatment is still controversial. We do know some definite facts. Patients with local recurrence or residual cervix cancer after radium treatment, but without bladder and rectal involvement, have over 40% five year "cures" after radical hysterectomy and pelvic node dissection. Patients with cervix cancer invading the bladder and/or the rectum, either primarily or after radium, have a worthwhile chance of cure by partial or total exenteration. Later this winter, I hope to be able to show you a movie film on this subject. One sees in it a group of patients who were doomed to die, now well and free of disease years after exenterations.

On the subject of gastric cancer, I wish to mention a unique investigation. As you know, the overall cure rate is poor. We can derive a little comfort from the fact that of patients surviving "curative" subtotal resections—of these—34% are free of evidence of disease at five years. In 1951, Dr. Gordon McNeer and associates reported on one hundred and twenty patients who had had apparent "curative" subtotal resections, survived their operations, and later died and had post mortems. A moment's reflection shows this to be a most unusual study. It could be done only by combing many hospitals in a large city and combining their experience. What did he find?

1. Cancer in the gastric remnant in 50% of cases.
2. Cancer in the duodenum in 14% of cases.
3. Regional metastases in the perigastric nodes in 22% of cases.

That is, in 80% of these patients, the surgeon had failed to eradicate disease locally. We must conclude that the routine subtotal gastrectomy is inadequate. To answer this, a more logical and aggressive operation is presently practised at Memorial for gastric cancer. A thoraco-abdominal incision is used—the thoracic extension being made only when cure seems possible. The spleen, tail and part of the body of the pancreas, the greater omentum, most of the lesser omentum, the left gastric artery, the first part of the duodenum—all are removed "en bloc". If a four centimeter margin is

obtainable, a small gastric pouch is left. If necessary a total gastrectomy is done. We all recognize that total gastrectomy per se may not improve chances for cure. It has been shown that gastrointestinal tract cancer can extend several centimeters in the submucosa, hence the need for a 4 cm. margin. The jejunal loop is brought in front of the colon, as a retro-colic loop is more quickly blocked if cancer recurs. The long term results of this attack on gastric cancer are not yet known. The immediate mortality is not increased. One awaits with interest the reports that will come from this program.

To end these remarks on cancer surgery, may I emphasize that radical procedures are of most value in early lesions and must not be used only as last resorts in hopeless cases.

In the field of radiotherapy, Memorial Center is pursuing all modalities. Million volt machines and a cobalt unit are in routine use. A 24 million electron volt Betatron has been installed. There is a radon emanation plant and interstitial radon is used daily. Many patients with recurrent cancer nodules after neck dissection, or Commando operations, have their disease well controlled by radon seed insertion and small field, high dose, external radiation. Radioactive iodine, phosphorous and gold, are standard agents now, and as you know, gold is particularly valuable for pleural and peritoneal effusions. For osteogenic sarcomata in children, where prognosis is bad, a project has been underway, combining extremely heavy pre-operative radiation, followed immediately by amputation. This is an attempt to prevent dissemination of active cells at surgery. Studies of the biological effects of low, high, and super, voltage therapy are being done in the animal laboratory. Work has been published on the effects on liver metastases of combining radiation and chemotherapy.

The Division of Chemotherapy is very active and one hopes will prove most fruitful. To date, thousands of chemical compounds have been screened. Pharmaceutical houses, Universities, other research centers, and the Sloan Kettering scientists are continually synthesizing new molecules. All these must be screened. How are they screened?

1. Tissue culture—The test compound is used against normal and cancer cells in tissue culture.

2. Egg tests—The test compound is used against tumor implanted and growing in chick embryos.

3. Solid tumor screening—The test compound is injected into mice who already have artificially

established sarcoma growing in them. Sarcoma 180 is a common tumor used thusly.

4. Tumor spectrum screening—The test compound is used against a number of rat and mice tumors. It is the rule rather than the exception to find a marked variation in the effect a given compound has on several tumors.

5. Leukaemic tests—The test compound is used against mice previously inoculated with a suspension of leukaemic cells or splenic emulsion.

Following this screening program, promising compounds are turned over to the division of pharmacology where half-lethal doses, toxic doses, and minimal doses are worked out. Then, and only then, are the few promising drugs given to patients and careful serial observations are made. Of the many drugs investigated this side of the Iron Curtain only a few valuable chemotherapeutic agents have come to light. They are useful mainly in the lymphomas and the leukaemas. Nitrogen mustard, T.E.M., and the antifolics, amethopterin and Aminopterin, are in routine use. Urethane is still used for multiple myeloma. The antifolics and cortisone given in sequence help leukaemic patients. 6-Mercaptopurine upsets nucleic acid metabolism and aids leukaemic patients who show resistance to the antifolics and cortisone. All these substances give temporary, but not permanent relief.

In the hormone field, a most interesting work is in metastatic breast cancer. Drs. Pearson and West and their staff, which includes Dr. John McLean, former Medical Resident at the Winnipeg General Hospital, have been studying calcium levels in patients with skeletal metastases from breast cancer. They have shown that some of these patients have a cyclic variation in calcium output varying with the menstrual cycle. These patients prove to be the ones whose tumors are hormone dependent. They are benefited by oophorectomy, and when they relapse, by adrenalectomy, and later hypophysectomy.

An unusual coincidence took place in this regard. An actress, resident in New York for many years, but originally from Winnipeg, came to Memorial Out-Patient Clinic with metastatic breast cancer. She was examined and sent in by Dr. William McLean, former Surgical Resident, from Winnipeg. She was attended on the research ward by Dr. John McLean, former Medical Resident from Winnipeg. She finally came to bilateral adrenalectomy done by myself—from Winnipeg.

In conclusion, may I express my pleasure in being home, and thank you for your kind invitation to address you this evening.

Complete Cancer Reporting in Manitoba

H. Blondal, B.Sc., E.E., M.D.

In Manitoba, cancer has been a reportable disease, by law since 1930. At that time, it was realized that in order to properly diagnose and treat cancer, we had to know something about the incidence and mortality of the disease. It is now classed as a notifiable disease under "The Public Health Act," along with the various infectious diseases whose nature demands a mandatory reporting scheme.

In 1937, a central registry was established at the Manitoba Cancer Institute to record and study this information. By the end of 1953, a total of more than 28,000 cases were on record at the registry. Enough data has now been gathered to begin studies on the incidence and mortality trends of cancer in the province over the last 10 to 15 years. These investigations and others including five-year studies of specific groups of cancer classified according to site, are now in progress.

These studies can be only of a general nature however, because of the limited amount of information available on each report. The present cancer registry was not designed to accomplish more than this. Studies of a more comprehensive nature concerning details of history, diagnosis, pathology, various forms of therapy, and follow-up, have been carried out at our larger hospitals where local tumour registries and follow-up services are available. Those brave souls who have attempted to review a couple of hundred cases from a particular point of view, are only too well acquainted with the labor and frustration involved.

However, there is no doubt that we require this detailed information for our fuller understanding of the cancer problem. This fact being accepted, it is the purpose of this article to present to the medical profession of Manitoba, a plan for attaining this end on a province-wide basis. We feel that we have a unique opportunity in Manitoba of achieving complete cancer recording, and that no time should be lost in taking advantage of this opportunity.

Fortunately, we already have a firm foundation upon which to build. Our plan is to modify and enlarge the function and scope of the present cancer registry at the Institute to cope with the increased complexities that a more comprehensive system will bring about.

The only practical method of handling large quantities of data of this nature is to design a master or abstract card on which each detail can be entered and assigned a code number. Once the abstract card is completed, it becomes a relatively

simple matter to transfer the information to a mechanical punched-card system which will be housed in the central registry of the Institute. When the system is functioning, the required information is quickly available by simple manipulation of the sorting machine.

The secret of success of such a system is the abstract card. After considerable local study, and valuable help and advice from the statistical department of the National Cancer Institute, two abstract cards have been designed. The need for a dual system was realized when it was found that in Manitoba we have, broadly speaking, two sources of cancer information. Approximately 60% of our information will come from the two large teaching hospitals in Winnipeg. The source of the remaining 40% comes from the other Winnipeg hospitals, the rural hospitals, and the rural doctors. There is no fundamental difference in these cards, they differ only in detail. The abstract card which will be distributed to the Winnipeg General Hospital and the St. Boniface Hospital will specifically request such details as radiation dosimetry, etc. A simplified card in which irrelevant details have been eliminated, will be distributed to the other city hospitals, to rural hospitals, and the rural doctors.

The reverse side of the abstract card has been designed to record the results of treatment and general follow-up of the patient. They are the same for both cards. The front and reverse sides of the simplified version of the card is shown in detail in the accompanying illustration.

It is contemplated that the doctors concerned will be requested to fill in the necessary details, and forward the card to the central registry of the Institute, on completion of the treatment. Follow-up will be carried out yearly. The Institute will contact the doctors and the institutions concerned at the proper intervals and specifically request these facts. This information will be transposed to the abstract cards and remain on permanent file at the Institute.

It is important to point out at this time that the abstract cards **must** be filled in or checked by qualified medical personnel. If this rule is not adhered to, it is inevitable that inaccuracies and omissions will decrease or nullify the value of the system.

It is felt that the importance underlying this project is well understood by the medical profession, and it is anticipated that there will be whole-hearted co-operation by all concerned. There is only one way of really finding out if a plan such as the one described will be successful — and that is to try it out.

DATE OF ADMISSION _____ MONTH _____ YEAR _____
DATE OF 1ST TREATMENT _____

- 2. MULTIPLE PRIMARYS
- 5. PRE-MALIGNANT
- 6. NON-MALIGNANT NEOPLASTIC
- 7. NON-NEOPLASTIC

IDENTIFICATION - CLASSIFICATION

TREATMENT

NAME _____

ADDRESS _____

STATUS: PRIVATE ☐ PUBLIC ☐ (15) AGE _____ (16-17)

SEX _____ MARITAL STATUS _____ NO. OF CHILDREN _____ (18)

MENOPAUSE (CHECK ONE) _____ (19)

- 1. PREMENOPAUSAL
- 2. CONCURRENT
- 3. POST-MENOPAUSAL-NATURAL
- 4. POST-MENOPAUSAL-ARTIF-SURGERY
- 5. POST-MENOPAUSAL-ARTIF-RADIATION
- 6. NOT APPLICABLE

SITE OF TUMOUR _____ (20-23)

HISTOLOGICAL CLASS _____ (24-27)

CLINICAL STAGE _____ (28) PATH. STAGE _____ (29)

GRADE OF TUMOUR _____ (30) CYTOLOGY 0 1 2 3 4 5 (31)

LOCATION OF TUMOUR _____ (32)

COMPLICATING DISEASE OR CONDITION _____ (33)

DURATION OF SYMPTOMS IN MONTHS _____ (34-35)

TIME BETWEEN 1ST CONSULT. AND TREATMENT _____ (36-37)

METHOD OF DIAGNOSIS: 1. CLINICAL 2. BIOPSY (38)

- 3. SURG. SPECIMEN
- 4. X-RAY
- 5. CYTOLOGY
- 6. AUTOPSY

PATH. LAB. _____ YEAR _____ PATH. NO. _____ (39-45)

PHYSICIAN:

RADIOTHERAPIST:

SURGEON:

(79-80)

INTENT OF TREATMENT (46)

- 1. CURATIVE ☐ REASON _____
- 2. PALLIATIVE ☐ REASON _____
- 3. NOT TREATED ☐ REASON _____

PLAN OF TREATMENT TO PRIMARY (47-48)

- 1. _____
- 2. _____
- 3. _____

PLAN OF TREATMENT TO SECONDARY (49-50)

- 1. _____
- 2. _____
- 3. _____

COMPLETENESS OF TREATMENT (51)

- 1. COMPLETE ☐ REASON _____
- 2. INCOMPLETE ☐ REASON _____
- 3. NOT TREATED ☐ REASON _____

SURGICAL METHOD

TO PRIMARY _____ (52)

EXPLORATORY OR PALLIATIVE _____ (53)

TO SECONDARY _____ (54)

RECONSTRUCTIVE _____ (55)

OTHER SURGERY _____ (56)

RADIOTHERAPY (57-67)

STATE TYPE OF RADIATION, TOTAL MAX. AND MIN. TUMOUR DOSE, FRACTIONATION, DURATION AND TECHNIQUE.

COMPLICATIONS OF TREATMENT _____ (68)

SITE OF FIRST RECURRENCE _____ (69)

INTERVAL FROM TREATMENT TO RECURRENCE

IN MONTHS _____ (70-71)

DATE AND CAUSE OF DEATH (STATE WHETHER PRIMARY, SECONDARIES, CONTROLLED OR NOT) (72)

DURATION OF LIFE (FROM TREATMENT, OR FROM

DIAGNOSIS IF UNTREATED) IN MONTHS _____ (73-75)

PATIENT'S OCCUPATION _____ (76-77)

FAMILY HISTORY _____ (78)

INITIAL CONSULTATION - WAS PATIENT INFLUENCED BY LAY EDUCATION - I.E. MEETINGS, FILMS, ETC.? YES ☐ NO ☐ (OVER)

YEAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
REPORT BY DOCTOR																				
REPORT BY NON-MEDICAL																				
ALIVE AND FREE OF DISEASE																				
ALIVE AND WELL FOLLOWING TREATMENT OF RECURRENCE DURING YEAR																				
ALIVE WITH DISEASE																				
ALIVE — INDETERMINATE RE PRESENCE OF DISEASE																				
DIED OF DISEASE																				
DIED OF EXTRANEIOUS DISEASE																				
UNTRACED																				
CODE																				

34-35 36-37 38-39 40-41 42-43 44-45 46-47 48-49 50-51 52-53 54-55 56-57 58-59 60-61 62-63 64 65 66 67 68

TREATMENT OF RECURRENCES

SYMPTOMATIC TREATMENT

(72)

RECURRENCE	1ST	2ND	3RD
SURGERY			
RADIOTHERAPY			
CHEMOTHERAPY			
COMBINATIONS			
CODE			

REMARKS:

69 70 71

DATE AND CAUSE OF DEATH

(75)

DURATION OF LIFE

(76-78)

POST MORTEM YES ☐ NO ☐ UNKNOWN ☐

(79)

M.C.I. SERVICE: BIOPSY ☐ CANCER DIAGNOSTIC ☐

NEITHER ☐ (80)

Orthopedics

Syme's Amputation

Alexander Gibson, F.R.C.S. (Eng.)

No good surgeon likes performing an amputation. When it has to be done, it should result in a stump which is painless and adaptable to a functional prosthesis. At the same time it should be such as to set the patient as little apart as possible from his fellows. Of all amputations the Syme's amputation most consistently fulfils these conditions. It is the one amputation that a surgeon may perform with much less than the usual amount of regret, for it promises a stump which is painless, and a gait which is almost normal.

In Scotland, Syme's amputation has always enjoyed a high reputation. It was never popular in England, and indeed came in for round condemnation in a report published by the Ministry of Pensions as late as 1939. Of recent years there has been a turn of the tide; in Canada and the United States it is rapidly acquiring increased prestige. There is only one explanation for the denigration of this procedure; it has not been properly done.

There are three classical amputations of the foot:

1. **Lisfranc's.** This is a disarticulation at the tarso-metatarsal joints. The recessed base of the second metatarsal may be dissected out, or sawn across.

2. **Chopart's.** The trans-tarsal joint passes across the foot from side to side. On the medial side it separates the talus from the navicular; on the lateral side, the calcaneus is posterior and the cuboid anterior. This is sometimes called the Chopart joint, for it is through this joint that the Chopart amputation is performed. The Chopart procedure is sometimes successful, but very often it gives trouble. The foot is a balanced unit. Removal of the fore part of the foot upsets that balance, and very often the heel becomes drawn up, and the most distal part of the stump becomes plantar flexed in consequence of the unimpaired pull of the calf muscles through the tendo Achillis. The skin over the end of the stump generally forms thick calluses and even pressure sores, which prove intractable. One advantage of the Chopart amputation is that the apparatus required after it is simple; a steel bar in the sole of the shoe and some stuffing to take the place of the absent forefoot. Syme himself paid a warm tribute to the merits of the Chopart operation:

"The operation of Chopart which leaves only the astragalus and os calcis is the most valuable of all partial amputations, as it commands the largest portion of the foot requiring removal for disease or injury, and at the same time preserves a support for the patient not less useful than that which is

afforded by the whole of the tarsus. Its introduction was long opposed on the ground that the extensor muscles of the ankle, acting through the tendo Achillis when no longer antagonised, would draw up the heel, and point the cicatrix to the ground. I performed this operation in 1829, so far as I know, for the first time in Edinburgh, and have frequently done so since with the most satisfactory results, no inconvenience having been experienced from the source just mentioned, as the cut extremities of the tendons on the fore-part of the joint speedily acquired new attachments enabling them to counteract the extensive power."

Experience since these days has shown that the Chopart operation does not "stand the gaff" as well as the measure introduced by Syme himself.

3. **Syme's.** This was introduced as an alternative to amputation below the knee. He lists the advantages as follows:

- "(1) The risk of life will be smaller.
- (2) A more comfortable stump will be afforded.
- (3) The limb will be more seemly and useful for support and progressive motion."

Later, he says of the operation, "I regret having cut off many limbs that might have been saved by it, and shall be glad if what has been here said encourages others to its performance." Syme builded better than he knew.

The operation was first performed by him in 1842, and was described in *The London and Edinburgh Monthly Journal of Medical Science* for February, 1843. The patient, a lad of 16, had "disease of the foot which had suppurated and ulcerated. It would have been necessary in accordance with ordinary practice to remove the leg below the knee, but as the ankle joint seemed to be sound, I resolved to perform disarticulation there. With this view, I cut across the integuments of the instep in a curved direction with the convexity towards the toes, and then across the sole of the foot, so that the incisions were nearly opposite to each other. The flaps thus formed were now separated from their subjacent connexions which was readily effected, except at the back where the firmness of texture caused a little difficulty. The disarticulation being thus readily completed, the malleolar projections were removed by cutting pliers."

Inevitably, many modifications in detail have been made. Harris has emphasised the fact that the fibro-fatty pad under the calcaneus is divided into compartments and that the integrity of this cushion must be preserved. This disposes of a modified incision advocated in a recent publication suggesting an ellipse around the point of the heel. One disadvantage of the Syme operation is that a "dead space" is left between the heel flap and the

bone stump. The extent of this space can be lessened by inclining the plantar incision backwards in accordance with the prominence of the heel, so that the plantar flap is shortened. With these points in mind, details may now be given of the technique that has proved uniformly successful over many years.

(1) The Incision.

(a) This commences at the tip of the lateral malleolus, and passes across the sole of the foot to a point directly opposite on the inner side. This point is generally about half an inch below and behind the tip of the medial malleolus. The cut is made down to the bone and should be completed in one sweep. It must not go to the tip of the medial malleolus or there is a risk of cutting the medial plantar branch of the lateral plantar artery, the chief vessel of supply to the plantar flap.

(b) The two extremities of the incision are then joined across the dorsum of the foot by the shortest route; this generally corresponds with the level of the ankle joint.

(2) Disarticulation.

The foot is grasped in the operator's left hand and then the bone is dissected off the flap, not the flap off the bone. This method of expressing the procedure is to emphasise that on the plantar surface the fatty compartments must be left intact. It has been suggested that a thin layer of bone should be peeled off in order to ensure the safety of the fat pad. This is neither necessary nor desirable. A second advantage of keeping close to the bone is that the risk of arterial damage is lessened. This completes the plantar flap.

(3) Trimming the Stump.

The periosteum covering tibia and fibula should be cut around just above the level of the ankle joint, and is then stripped upwards with a raspator. What is wanted is a stump with as broad a surface as possible and this is obtained by sawing through both bones just proximal to the cartilaginous covering on the distal surface of the tibia. Both bones should be trimmed in the one transverse cut, the fibular section being completed before that of the tibia. If, after section a small amount of articular cartilage is still visible, it does not matter. The shaft of the tibia forms an acute angle with the new distal surface, and this acute angle may be rounded off with bone-cutting forceps and a wood rasp.

(4) Closing the Flaps.

A subcutaneous suture of catgut may be used to approximate plantar to dorsal flap, followed by closure of the skin wound.

(5) Stab Drain.

This is as important as any step in the operation. The cavity left by removal of the posterior tarsus

is roomy, and, apart from oozing from the soft parts, the raw ends of the tibia and fibula are sure to bleed. Accordingly, a Penrose drain is inserted through a stab wound and left for 24 hours, at the end of which time bleeding has ceased and the drain may be removed.

(6) Bandaging.

The stump is bandaged with an ordinary stump dressing and an elastocrepe bandage. This should be removed for inspection every day or two so as to make sure that the heel-flap heals in the best possible relation to the leg. If the heel flap is too loose, or if it should be displaced (generally backward and/or to the inner side) the functional result will be unsatisfactory.

(7) Removal of Stitches.

Stitches should be left in for 12 to 14 days. If the heel flap is not in perfect position, it may be persuaded to assume better relation to the leg by strips of adhesive plaster.

(8) Measurement for Prosthesis.

This may be done about four weeks after operation, and patient may commence to use it about four weeks after that. The prosthesis is always rather massive for it has to stand up to rough usage, but it can always be made comfortable.

The Pirogoff operation is a modification of the Syme which uses the plantar portion of the calcaneus to close the end of the tibia just as the patella does to the femur in the Gritti-Stokes amputation at the knee. The Pirogoff operation is a little more difficult technically than the Syme, and is not so desirable functionally. It leaves a stump too long for an ankle joint to be fitted in its normal situation in the prosthesis, thus making the Pirogoff amputee a "heel-walker."

It is difficult to follow cases of Syme's amputation. They resume their ordinary occupations including such rigorous ones as prospecting, truck-driving or climbing telephone-poles. Only rarely are they seen again. Since the prosthesis is bulky the Syme amputation is for cosmetic reasons not suitable for women. One great advantage of the Syme amputation is that it gives an end-bearing stump. The increased chance of escape in an emergency as a fire or a train wreck at night is apparent. It must be fully understood that the Syme operation requires meticulous workmanship and careful post-operative supervision. One may summarize the main points:

1. Commence incision at **Lateral Malleolus**.
2. Dissect the bone off the flap.
3. 24-hour drain.
4. Watch the position of the heel-flap.

Careful attention to these points will ensure gratifying results.

Clinico-Pathological Conference

Deer Lodge Hospital

Clinico-Pathological Conference No. 123

April 20, 1954.

Mr. W. R. Age 31.

January, 1943—Malaria and jaundice in North Africa. Hospitalized and on examination found to have mitral stenosis. No previous history of rheumatic fever, dyspnoea on exertion.

January, 1944—Began to notice pains in chest, hips, knees and feet, while in England. Since then has had periodic sharp razor pains in anterior chest. No history of febrile episodes, no positive blood culture, malaria and S.B.E. excluded.

Prior to discharge in November, 1944, patient is recorded as having malaria, infectious hepatitis and V.D.G.

January 6, 1946—Admitted to D.V.A. with same complaints.

September, 1946—Precordial pain, chills, fever and emesis, diarrhoea. Blood culture and stools negative. Impression: Well compensated mitral stenosis.

February, 1947—Fatigue, hemoptysis, pains in knees and ankles in addition to above. Put on penicillin.

October, 1947—Re-admitted complaining of pain in left precordium, dyspnoea, palpitation, dull ache in hips, knees and ankle joints, periodic chills and sweats, loss of 15 lbs. in weight since March, 1947.

December, 1948—Same complaints. Psychiatric assessment—inadequate personality. Having much domestic difficulty.

May, 1950—Same complaints following heavy work.

February, 1951—Another admission for same complaints.

January, 1952—Dyspnoea, severe chest pain, hemoptysis, low grade fever, one out of 2 cultures positive for strep. viridans after 3 weeks. Given a total of 80,000,000 units of penicillin.

April 4, 1952—Re-admitted after being out of hospital only a few days. Complaints are hemoptysis, breathlessness, sharp tearing chest pain in the left mammary region. Says that at times pain is associated with the heart beat, and at others it was associated with inspiration. Blood cultures taken again and patient put on penicillin and later tried on aureomycin. No growth in cultures.

June, 1952—Acute pulmonary edema occurred very suddenly. Responded to usual measures. Penicillin given for swinging temp. Cortisone given with no benefit.

July 25, 1952—Episode of pain of sudden onset in left upper abdomen and vomiting.

August 4, 1952—Tearing pain in right chest, hemoptysis, apprehension and restlessness. No evidence of shock. Dull aching pain in knee and front of leg down to ankle, right side. Leg is cooler and no pulses felt on this side.

Sept. 14, 1952—Patient shows cyanosis of lips, orthopnoea, pinkish frothy sputum. O.E. rales over both bases, some liver tenderness. Fibrillating, also complaining of "tearing" pain along the right anterior border of the chest, and retrosternal pain. These symptoms are accompanied by severe chills and sweating.

Also has some pain in legs suggestive of being vascular in nature. Hgb 80%; RBC 4,000,000; ESR 6 mm.

October, 1952—Pain in L.L.Q., L.C.M., and left shoulder, worse on breathing. Patient perspiring freely. Continues to be a nursing problem. Is belligerent and emotional.

X-ray chest: Marked prominence of pulmonary artery segment and left auricular appendages. No RBC's in urine.

December, 1952—Transverse diameter of heart increased. Put on digitalis for fibrillation.

E.C.G.—Auricular fibrillation, probably mitral stenosis.

February, 1953—Admitted in gross C.H.F. Two blood cultures negative.

March, 1953—Patient vomits after each meal. This is thought to be psychogenic. Negative G.I. findings on x-ray.

June 21, 1953—Admitted again after a drinking bout. Had a bout of hemoptysis and was in mild C.H.F.

July 5, 1953—Severe attack of chest, back, head and leg pain accompanied by severe sweating. Palpable liver.

E.C.G.: Auricular fibrillation, right ventricular hypertrophy and ischemia. Blood and urine normal.

October 1, 1953—B.S.P. 22% retention half hour. Thymol turbidity 3 units, Thymol flocculation XXX; Ceph. Flocculation XXX. B.U.N. 13 mg. %; Blood Sugar 50 mg. %.

October 4, 1953—Patient had an attack of severe pain, tearing in character in the right chest, stabbing over the heart, gagging, nauseated, perspiring. Looks like a man who has had an air encephalogram. Light headed, numb all over.

Has now developed clumsiness and inability to feel properly with the left arm.

November, 1953—Noted to have diminished pulse right leg and slight facial weakness on the right. Discharged.

January 29, 1954—Cardiac catheterization and mitral valvulotomy. Mitral valve noted to be calcified at operation. Valve leaflets broken down. Immediate post-operative condition satisfactory.

Patient began to spike a temperature a few days post-operatively. A gram negative bacillus was subsequently cultured on 4 different occasions from the blood. Patient was put on full dosage of a wide variety of antibiotics and finally cortisone but his fever continued, he lost weight and terminally became severely jaundiced and died March 24, 1954.

Autopsy Findings

The body is that of a 31-year-old white male, measuring 5' 7" in length and weighing 117 lbs. The body is markedly jaundiced. The head is covered with black hair. The pupils measure 5 mm. in diameter and are equal. There is no palpable lymphadenopathy.

There is a semi-circular scar on the left chest running from near the sternum to the axilla, the site of a previous incision for valvulotomy. This is very well healed.

The abdomen is grossly distended and tympanic. There are no abdominal scars. The lower limbs exhibit mild edema below the knees. There is an abrasion of the right knee cap. There is no abnormality of the upper limbs.

Cranial Cavity

There is no abnormality of the meninges. The brain is palpated and no areas of softening are found. The brain feels normal in consistency. The gyri and sulci are normal in consistency, size and shape. The basilar vessels show no atheroma. The ventricles are opened into and the left ventricle is normal in size and configuration. The choroid plexuses appear normal. The ventricles contain a normal amount of C.S.F. The right ventricle exhibits some milky fluid which could be pus, and a culture is taken of this which shows *B. Friedlanders*, and *Strep. gamma*. The pituitary appears normal. The brain weighs 1230 gms.

Thoracic Cavity

The thyroid appears normal.

The chest is opened. There are adhesions of the right upper lobe and also of the mid zone of the left lung. The base of the right lung is firmly adherent to the diaphragm. There is fluid in each pleural cavity, the left is blood stained, the right is clear, amounting to approximately 100 cc. on either side.

The pericardium is opened and a fibrinous adherent pericarditis is found. The pericardium has to be stripped from the heart proper. The heart is examined and contains, at the previous site of the left auricular appendage, sutures where the defect had been repaired. The heart is removed and weighs 450 gms. On examination there is marked softening of the right auricle. The left

auricle is opened and the mitral valve is found to be markedly narrowed and calcified, and would not even admit the tip of one finger. The heart is opened along the left ventricle and the mitral valve examined. Overlying the site of suture line from whence the auricular appendage was removed, there is a large thrombus adherent measuring approximately 2 x 3 cms. The valve cusps themselves are markedly calcified and there is a large friable vegetation measuring 2 x 2 cms. in diameter adherent to the mitral ring. The remainder of the heart is not examined as the specimen is retained intact for further examination.

The right lung weighs 860 gms. There is an old pleurisy present. On section there is marked congestion and edema.

The left lung weighs 750 gms. and is essentially similar to the right.

Abdominal Cavity

On opening the abdomen distended bowel protrudes immediately through the opening. There is also approximately 300 cc. of bile stained fluid. The liver appears to be enlarged about 2 fingers below the costal margin. The organs examined in situ appear normal.

The liver weighs 1990 gms. and appears to be hemorrhagic and granular on the surface. On section it shows hemorrhagic areas interspersed with pale areas of liver tissue. The gall bladder is examined and contains about 2 cc. of very viscid bile and contains approximately 9 small calculi.

The spleen weighs 350 gms. and is enlarged. On section it shows recent and old infarctions.

The adrenals appear normal.

The right kidney weighs 200 gms. On section it appears normal. The cortex is well differentiated from the medulla and of normal size.

The left kidney weighs 200 gms. and is essentially similar to the right.

The bowel is removed and examined along its entire length and appears normal. The stomach and duodenum are opened and appear normal. The appendix is removed.

The bladder and prostate are removed. The bladder is opened and examined and shows a mild granular cystitis. The prostate appears normal in size and consistency.

The pancreas appears normal.

Microscopic Findings

Heart—Shows the pericardium markedly thickened by a fibrinous exudate containing an infiltrate of polymorphs, lymphocytes and a few multinucleated giant cells and plasma cells. Many of the capillaries in the myocardium are crowded with polymorph leucocytes, and there is some wandering of these cells between the myocardial fibres. No typical rheumatic lesions can be seen.

Left Lung—Shows marked atelectasis with the presence of many brown pigment filled histiocytes. Upper lobe is also atelectatic and congested.

Right Lung—Section also shows a similar condition to that of left but not quite so severe. Pigment filled histiocytes are particularly numerous, and some multinucleated giant histiocytes are seen.

Liver—Shows marked congested and marked parenchymatous degeneration with moderate increase in fibrous trabeculae. Appearance is that of a sub-acute liver atrophy.

Spleen—Shows multiple areas of infarct—some pale—others hyperaemic.

Pancreas—Nothing of note.

Testicle—Nothing of note.

Adrenals—Show hyperaemia.

Kidneys—Distal tubules are seen to contain yellowish brown casts as seen in cholaemic nephrosis. The epithelium of proximal tubules is swollen.

Prostate, Appendix, Pituitary, Thyroid—Nothing of note.

Vegetation on Mitral Valve—Section shows the vegetation made up of fibrin—blood clot infiltrated by leucocytes and with numerous bacterial culture areas.

Lenticular Nucleus—Section shows liquification necrosis without inflammatory reaction.

On section of the hardened brain there is a softened area immediately lateral to the anterior part of the right ventricle, oval in shape, and measuring 3.5 cms. long and 2 cms. in greatest width, completely replacing the anterior half of the basal ganglia (area of lenticular nucleus).

Total copper content of liver—slightly lower than normal.

The clinical and pathological entity known as Wilson's disease is represented by 2 distinct and separate lesions occurring simultaneously. There is a cirrhosis of the liver (Laennec type) and a degeneration of the lenticular nucleus. Both of these are progressive.

The lenticular lesion is a pure striatal lesion, it may involve the caudate nucleus as well, but never touches the thalamus. The degeneration first leads to softening and then to cavity formation.

The hepatic lesion differs not from Laennec's cirrhosis.

There is a third lesion due to deposition of copper derivations along the margin of the cornea—giving so-called Kayser-Fleischer rings. There also may be a sunflower cataract due to deposition of copper on the surface of the lens.

The Etiology

Supposedly, due to inborn error in the metabolism of copper. Copper is excreted normally in the bile and the urine. In Wilson's disease there is an excessive amount of copper deposited in organs such as the liver and kidneys. The serum has decreased copper content and the urine content is increased.

The suggested cause is an over-absorption of copper from the bowel. It has been proved experimentally that cirrhosis of the liver can be produced by feeding animals with copper. Also it has been shown that if the hepatic artery is ligated or by-passed in experimental animals, the resultant liver damage is often associated with severe cerebral damage.

Experiments have lately been performed which suggest that certain of the urinary findings in Wilson's disease, are due to kidney damage resulting from faulty copper metabolism. This is shown by the presence of abnormally large amounts of certain amino-acids in the urine. The most consistent of biochemical findings in all cases of Wilson's disease is a reduction in the serum of the conjugated copper protein — ceruloplasmin. At autopsy there is an increase in the copper content of all organs.

Clinical Picture

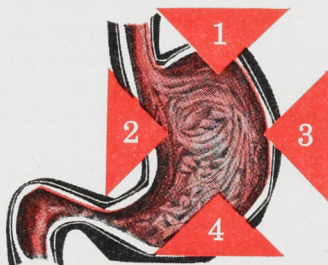
Presents itself usually in adults between ages of 20-30. It is familial and progressive; i.e., other members of the family should be seen. The symptoms of cirrhosis of the liver are present together with muscular rigidity, tremor of Parkinson type, difficulty in articulation and very marked emotionalism.

The above is a description of the true familial Wilson's disease. It has been shown, however, that degenerative lesions of the liver in man may be associated with necrotic foci in the corpus striatum apart from Wilson's disease. We believe that the described case may be one of these.

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Sodium Lauryl Sulfate . . . 25 mg.
Methylcellulose 100 mg.

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Prescribe two to four teaspoonsful
Kolantyl Gel or two tablets (chewed
for more rapid action) every 3
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Gel supplied in 12 oz. bottles—Tab-
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1. HUFFORD, A. R.; MICH. STATE MED. SOC. 49:1308,
1950. 2. MCARDY, G. AND BROWNE, D.; SOUT. MED.
J. 45:1139, 1952.

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Edited by Wallace Grant, M.D.

Spontaneous Hemorrhage in Childhood

Chairman: Dr. S. Israels

Dr. Israels: We are presenting this morning three children each of whom shows as part of his disease, an unusual bleeding tendency and Dr. Besant will lead off with the history of each of these children.

Dr. Besant: The first patient (A-6324) is an 11 month old baby girl who was admitted to hospital on August 21 from the Out-Patient Department. The baby had red swollen gums which oozed blood intermittently. There had also been evidence of extreme pain in the legs for one week preceding admission and the mother noted that the right leg especially was tender and slightly swollen, and it was used actively much less than the left. The outstanding features revealed on examination were a noticeable pallor, an extreme degree of irritability, no voluntary use of the right leg and some slight rash over her face and trunk. There was marked angulation at the cost-chondral junctions, noticeable tenderness over both knees, and the right knee was swollen and warm. The dietary history was especially important since the only food the child had ever taken was an evaporated milk formula which at the time of admission was made up with 8 ounces of evaporated milk, 16 ounces of water and 2 tablespoonfuls of corn syrup. There had been no vitamin supplement given, and according to the mother the child had always refused any solid food that she attempted to feed her. The clinical impression of the admitting intern was that the child had scurvy, and X-rays of the extremities, which will later be reported on by Dr. Childe, tended to support this diagnosis. Of especial interest to us was the submetaphyseal separation at the lower end of the right femur. The blood examination revealed a hemoglobin of 6.6 grams, erythrocytes of 4 million per cubic millimeter, reticulocytes 1.8%, hematocrit 27%, MCH 16.5 micro micrograms, MCV 67 cubic microns, MCHC 25%. The treatment given has been ascorbic acid 100 milligrams twice a day and the hospital's "diet for age." Although she is crying here, on the ward she is usually quite quiet and shows no tenderness over her legs. The orthopedic consultant recommended that the right leg should be splinted and a plaster posterior splint was applied yesterday.

Dr. S. Israels: Dr. Childe, would you point out the special features on the X-ray of this child.

Dr. Childe: The films of the lower extremities of this child show advanced changes, more than we have usually seen in recent years. The general changes are those of scurvy, the "ground-glass"



appearance of the bones, some "pencilling" around the epiphyseal centers, and white lines at the ends of the shafts. The striking feature is of course at the distal end of the right femur, there is a lot of soft tissue swelling and the epiphysis is displaced laterally, and there has been an extensive fracture through the distal end of the shaft (or sub-metaphyseal if you wish) so that there is a good deal of lateral displacement of this epiphysis. It is obvious that there must be an extensive subperiosteal hemorrhage at the distal end of this femur, in particular. But as is always the case, before treatment, we do not see the hemorrhage as such, we just see soft tissue swelling. Within a week or ten days, there will be evidence that the hemorrhage is organizing, with calcification in it. There will be very satisfactory progress from then on, although it will be some years before all signs of scurvy disappear. One can now only speculate as to how large the hemorrhage is and how far up the shaft it will extend. Sometimes it is sufficiently large to bury the whole shaft. Another X-ray this morning was taken through plaster (apparently the leg is now being protected) and in the A.P. view the displacement does not seem to have increased but in the lateral view it is displaced slightly backward. Now, I don't think we need get perturbed about it, I've never seen any permanent deformity result from these separations, presumably this is because the epiphyseal line itself, although it seems to be involved, is not involved, the separation occurring through the sub-metaphyseal region.

Dr. Israels: Do you think the child needs the plaster?

Dr. Childe: It won't do any harm, and it should certainly be more comfortable, but it won't be too long before the fragment becomes anchored solidly. I haven't seen treatment with plaster before, but I see no objection to it.

Dr. S. Israels: How do you feel Dr. Ferguson?

Dr. Ferguson: I am inclined to agree with Dr. Childe, some immobilization makes for greater comfort as long as the child is moving around. This is not a complete plaster cast, it's just a posterior splint, so it is really just a protector and it can easily be removed at any time.

Dr. S. Israels: Did you see much scurvy when you were in Montreal, Dr. Childe?

Dr. Childe: Yes, at one time I reviewed a hundred cases, one of them illustrating the type of thing that you can expect to see here, with tremendous sub-periosteal hemorrhage. I followed that child for two and a half years, and by that time you would not know that anything had happened to the shaft but you could still see the small transparent centers in the middle of the epiphyses.

Dr. S. Israels: Could you tell us what happens with separation?

Dr. Childe: The weakened zone is apparently sub-metaphyseal, not epiphyseal, and when you get separation or spurs, they are at the distal end of the shaft rather than at the extreme end.

Dr. Grant: It's really a fracture then?

Dr. Childe: Yes, and all children with scurvy have multiple fractures, but many of them are microscopic. When you get "cupping," you get microscopic fractures too. The sub-periosteal hemorrhage takes its shape because of the fact that the periosteum is tied down very firmly to the extreme end of the shaft of the bone, within a week to ten days there is evidence that it is organizing, and its distribution becomes more apparent.

Dr. J. Briggs: Can any of you tell me how many children with scurvy we have had in this area this year to date?

Dr. Coodin: I'd say at least twelve.

Dr. Briggs: I'm thinking of a boy I recently had in hospital who was a feeding problem at three years and developed scurvy, but why he hadn't shown it before I don't know.

Dr. Childe: He's the oldest I've seen. I'd seen a child of two and a half with scurvy before that but never one of three.

Dr. Briggs: The commonest locus for scurvy in England was the institution for mentally retarded children, especially in those children who were difficult to feed. These would often be children of 15 to 18 months.

Dr. Grant: This child is one who should show multiple nutritional deficiencies because he has lived on nothing but an evaporated milk formula for 11 months. For this reason we were especially anxious to get a hemoglobin, which proved to be 6.6 grams, a level not unusual in a severe nutritional anemia.

Dr. P. Barsky: Recently in Rochester, New York, I heard of a child with scurvy who had an associated sub-dural hematoma, and it was recommended there that these children should initially be treated with intramuscular injection of ascorbic acid to accelerate healing and perhaps forestall the development of this complication. I wonder if there is any evidence that Vitamin C given in this way is more readily made available or is it just more rapidly excreted?

Dr. Delory: My impression is that there would be no advantage to this type of administration.

Dr. Briggs: It seems to me that Dr. Popham had a patient with scurvy not long ago, and he was able to obtain the vitamin preparation that had been given to the child and, on analysis, it contained more than enough to prevent scurvy.

Dr. Delory: The important thing to remember about that is, that the method of estimating Vitamin C content utilizes a dye and depends on oxidation-reduction and there are many things which might produce this reaction other than Vitamin C.

Dr. Israels: What about this anemia? Dr. Grant thinks it's nutritional.

Dr. Briggs: The point is, if you were to give him Vitamin C alone would not the anemia respond just as well as it would to iron?

Dr. L. Israels: If this were so, the theoretical explanation would be that ascorbic acid is necessary for the conversion of folic acid to folinic acid which in turn is necessary for nucleic acid synthesis. If you don't have proper synthesis of nucleic acid you have megaloblastic marrow and the anemia tends to be macrocytic, although not necessarily so. Now this child had a very low mean corpuscular volume and a mean corpuscular hemoglobin which would suggest that a large part of this anemia was actually due to blood loss. But he has four million red cells per cubic millimeter and the hemoglobin is only 6.6 grams, so that there may be a dimorphic anemia here with possibly a preponderant element being due to the absence of iron.

Dr. S. Israels: Well, what about the relationship of Vitamin C to the absorption of iron?

Dr. L. Israels: Carl Moore has done some work on this in animals and he finds that by administering Vitamin C along with iron, he gets an increase of perhaps 5 to 10% in iron absorption. This is a large increase considering the amount of iron that is normally absorbed.

Dr. Ferguson: If you had a fracture with this amount of hematoma in an otherwise normal child of this age, I don't think you would be surprised to find its hemoglobin as low as 6.6 grams. You can lose a lot of blood around a fracture. Another thing I was thinking of is that there has been a lot of work done on the Vitamin C content of the adrenal cortex. Is there any evidence that there is some adrenal cortical disturbance with scurvy?

Dr. Aaron Malkin: Some of this work has been done in Maryland where they rendered individuals scorbutic and measured the corticosteroid output and I don't think that it was found to be much less in the scorbutic animals than in those that were normal.

Dr. Childe: Was the baby shown to be losing much blood in its urine?

Dr. Besant: The mother gave no history suggestive of it and the urinalysis showed no blood.

Dr. L. Israels: The interference in red cell production that can be produced by a lack of Vitamin C is at the normoblast level, (normoblasts and reticulocytes are not produced) but as soon as ascorbic acid or folic acid are available to remove the block, normoblasts increase in marrow and reticulocytes in peripheral blood. I think that the action of folic acid is mainly in the early normoblast stage.

Case No. 2

Dr. Besant: The second case (A-5139) is a 6 year old boy who was apparently feeling perfectly well until May of this year. At that time, on a visit to Toronto, his mother became aware of increasing weakness and lethargy, and noted swelling on one side of his face and of one leg. He was admitted to hospital in Toronto, a diagnosis of a myelogenous type of acute leukemia was made and he was treated with X-radiation to the involved areas and transfused with six bottles of blood. He was first seen in this hospital on the 1st of July of this year when he was extremely pale, the spleen and liver were enlarged, there was generalized but rather minimal enlargement of lymph nodes and lymphoid tissue in the pharynx. Blood study at that time revealed a hemoglobin of 3.6 grams, a leucocyte count of 19,500 (mature pmn. 6, immature pmn. 6, lymphocytes 58, prolymphocytes 9, myeloblasts 21) and platelets 98,000 per cubic millimeter. Before admission to hospital he was receiving 6-mercaptopurine (a 50 mgm. tablet daily), and on admission to hospital he was given a blood transfusion of 500 c.c. He was admitted again on July 15th and given a transfusion of 1000 c.c. Again on the 31st of July he was given a transfusion of a litre of blood. His fourth admission to this hospital was on the 10th of August, and at this time the 6-mercaptopurine was increased to 1 tablet twice a day (except twice a week when he was given only 1 tablet for the day), and he was given a further transfusion of 900 c.c. of blood, and aureomycin. By the 18th of August his white count was 27,500 and there were 18,000 platelets. On that day he was started on cortisone, 50 mgm. twice daily because he seemed to be going down hill in spite of the treatment he was receiving. On August 21st he suddenly developed a massive swelling on the right side of his neck largely in the submandibular region, with lesser swellings in the right groin and left elbow. On the same day his cortisone was reduced to 25 mgm. three times daily and he was started on penicillin. On August 27th his white count was 2,700 and on the 23rd it had been 8,300. There had been steady enlargement of the spleen from the time he was first put on 6-mercaptopurine in July and at the time of his last admission it extended to 2 or 3 fingers below the level of the umbilicus. Since the cortisone was begun the spleen has diminished to size so that its edge is now 1 or 2 fingers above the level of the umbilicus.

Dr. S. Israels: Dr. Boyd would you comment on the presentation so far?

Dr. S. A. Boyd: I prefer to leave most of the discussing to Dr. Lyonel Israels who has been the consultant in treatment. I saw the boy, I think it was last February, for an inter-current illness and he seemed to be quite alright then. There was certainly no evidence of leukemia from the clinical point of view. It wasn't until about the time that he went to Toronto that he began to show signs due to leukemia. When he developed this large swelling in his neck quite suddenly, the problem was whether it was primarily due to infection or whether it was hemorrhage. Dr. Ferguson has been looking at it and I would be interested in his impression, and his opinion as to the treatment if it is hemorrhage.

Dr. Ferguson: There is considerable discoloration over the swelling and it gives the impression of being a hematoma. I would be inclined to leave it entirely alone for a long time, as long as possible.

Dr. S. Israels: What do you think, Lyonel? Is this a common type of leukemia in children?

Dr. L. Israels: Yes, it is. The classification of this leukemia is a little difficult and I think it depends on the impression of the morphologist. The cells are very small, they are blast forms, and he does have a small admixture of myelocytes and metamyelocytes and I guess if you want to pinpoint it, you could say it's a so-called micromyeloblastic leukemia. These myeloblasts are not the usual large form of cell and this type is often included with the lymphoblastic form, because if you just have the blast forms in the peripheral blood they are difficult to differentiate. I think the two most important aspects of this boy's disease for discussion are (1) the use of 6-mercaptopurine, (2) what does constitute a response in leukemia. On 6-mercaptopurine this boy's white count came down and was well controlled, but the hemoglobin did not rise. It stayed around 3 to 4 grams and his platelets continued to fall. So judging by the white count, (and much of the published data on the use of 6-mercaptopurine refers to the white count response) this boy was actually responding well. However, when you looked at the boy it was obvious that the nodes in his neck were increasing in size, his spleen was getting progressively larger, his platelet count was falling, and his hemoglobin was remaining at a fairly low level. The question then arose as to whether to start the boy on some other substance. Beginning cortisone with this child was not without danger, there have been many reports of a stimulatory effect of cortisone on the myeloblastic leukemias. The problem was complicated by the sudden appearance of the mass in his neck. It was not discolored. It was very hot and painful so it was difficult to decide whether it was hematoma or infection. If hemorrhage, was it due to

the effect of cortisone or was it the natural progress of his disease process or the continued rapid drop in platelet count which was probably from the 6-mercaptopurine? So the 6-mercaptopurine was discontinued and he was continued on cortisone for a total of 100 mgm. a day and he has made some improvement, the swelling now being considerably smaller than it was 3 days ago. He has stopped bleeding from his gums although his last platelet count was below 20,000. Here is an interesting feature of treatment of these people with cortisone, although the platelet count continued to fall the child stopped bleeding. The cortisone has probably exerted its effect on the vasculature with possibly a small effect on the circulating coagulation factors, but certainly hasn't done anything to the platelets as yet.

Dr. S. Israels: Dr. Delory, can you tell us what 6-mercaptopurine is?

Dr. Delory: A mercapto group is an SH group, in this instance attached at the 6- position to a purine ring.

Dr. S. Israels: How would that work, Dr. Malkin?

Dr. Malkin: The 6-mercaptopurine would probably substitute for another purine in the formation of deoxyribonucleic acid. The ribonucleoprotein is in the cytoplasmic portion of the cell (in the mitochondria) and the deoxyribonucleoprotein is in the chromosomes of the nucleus. The ribonucleoprotein in the cytoplasm is important in the synthesis of protein, and deoxyribonucleoprotein in the nucleus is required for the mitosis of the cell, hence its reproduction. Now all cells in humans have the same amount of deoxyribonucleic acid (DNA) except for the germ cells which have half the amount. In this situation the 6-mercaptopurine is probably substituting for the purine normally found in the nucleic acids in the cells and in this way interferes with cell division. The trouble with this explanation is that purines are synthesized in the body and it is hard to believe that the 6-mercaptopurine would find its way directly into the nucleic acids. For reasons similar to this it was found that the purine-deficient diet tried in the treatment of gout was ineffective, purines being synthesized anyway.

Dr. S. Israels: Would about the same mechanism account for the effectiveness of X-radiation?

Dr. Malkin: Well, yes, X-radiation would probably act on the nuclei in much the same way.

Dr. S. Israels: So these two types of therapy may have a similar basis to account for their efficacy.

Dr. Malkin: Unfortunately of course these poisons are not selective in action and quite commonly harm other cells besides the neoplastic ones.

Dr. J. Briggs: That was the question I was going to ask. Does that explain the fall in platelets and the persistent low hemoglobin in this child as well

as the fall in white count? Another thing is that after a while it seems as if the body cells "get wise" to these anti-leukemic substances and begin to utilize them in their growth. Furthermore the recession in the disease in this instance is, according to Farber's classification, nothing more than a clinical recession and although the patient looks better he is not really any better. What was the bone marrow picture?

Dr. L. Israels: We had no marrow examination. Certainly in this case we got only a partial hematological response, on the other hand, Burchenal, who has done a lot of work with this substance, does report cases with complete hematological remission, the platelets go up, the hemoglobin rises, and the marrow picture is normal.

Case No. 3

Dr. Besant: The third child (Case No. A 6195) is a 13 year old boy who was admitted in June to have several carious teeth extracted. He has had two previous admissions to this hospital, once in 1942 for dermatitis and again in June of 1944 because there was continuing bleeding for 12 hours from a cut to his lower lip, sustained in a fall. It was suspected then that he had a bleeding disorder, especially since one of his brothers had had three admissions to this hospital for what was diagnosed as Hemophilia. In 1944 the investigation of his bleeding demonstrated a prothrombin time of 20 seconds, a platelet count of 110,000 per cubic millimeter, bleeding time was 90 seconds, and clotting time was 4¼ minutes. Since that admission at 4 years he has done fairly well although he has had frequent nose bleeds, especially in the summer time, but these have been controlled at home. This spring his gums became appreciably swollen and oozed blood periodically, and his teeth were quite carious. Before planning the dental extraction, he was investigated again because of the bleeding disorder, and in June of this year his platelet count was 252,000 per cubic millimeter, his bleeding time was four minutes and his clotting time was ten minutes. On the sixth of August his bleeding time was nine minutes and his clotting time fifteen minutes and about this time Dr. Lyonel Israels did a thromboplastin generation test which was abnormal. On August 20th his bleeding time was ten minutes, his clotting time eight minutes and he was given two bottles of fresh frozen plasma following which his clotting time was seven minutes, or little changed. He was then given two more bottles of fresh frozen plasma before the dental extraction and two further bottles immediately after (each bottle containing 125 cc.). Following the extraction he continued to ooze slightly. Altogether he was given a total of 11 bottles of fresh frozen plasma. We have, at this time, uncovered more evidence of a family tendency to bleeding which is manifested by one uncle and two brothers (ten years ago the story was that only one brother was a "bleeder").

Dr. S. Israels: Dr. Ferguson, would you like to comment on the problems associated with surgery on hemophiliacs and the preparation of such a patient.

Dr. Ferguson: Wherever possible of course you should avoid operating on such patients but if surgery is necessary the patient should be prepared in the way that was done here, using fresh frozen plasma or fresh plasma or fresh whole blood. The degree of response to such preparation should be checked by doing bleeding and clotting times, and the treatment should be continued as long as is necessary to keep bleeding and clotting times close to normal.

Dr. S. Israels: Do you feel that local agents such as might be applied to the child's gums are of any value?

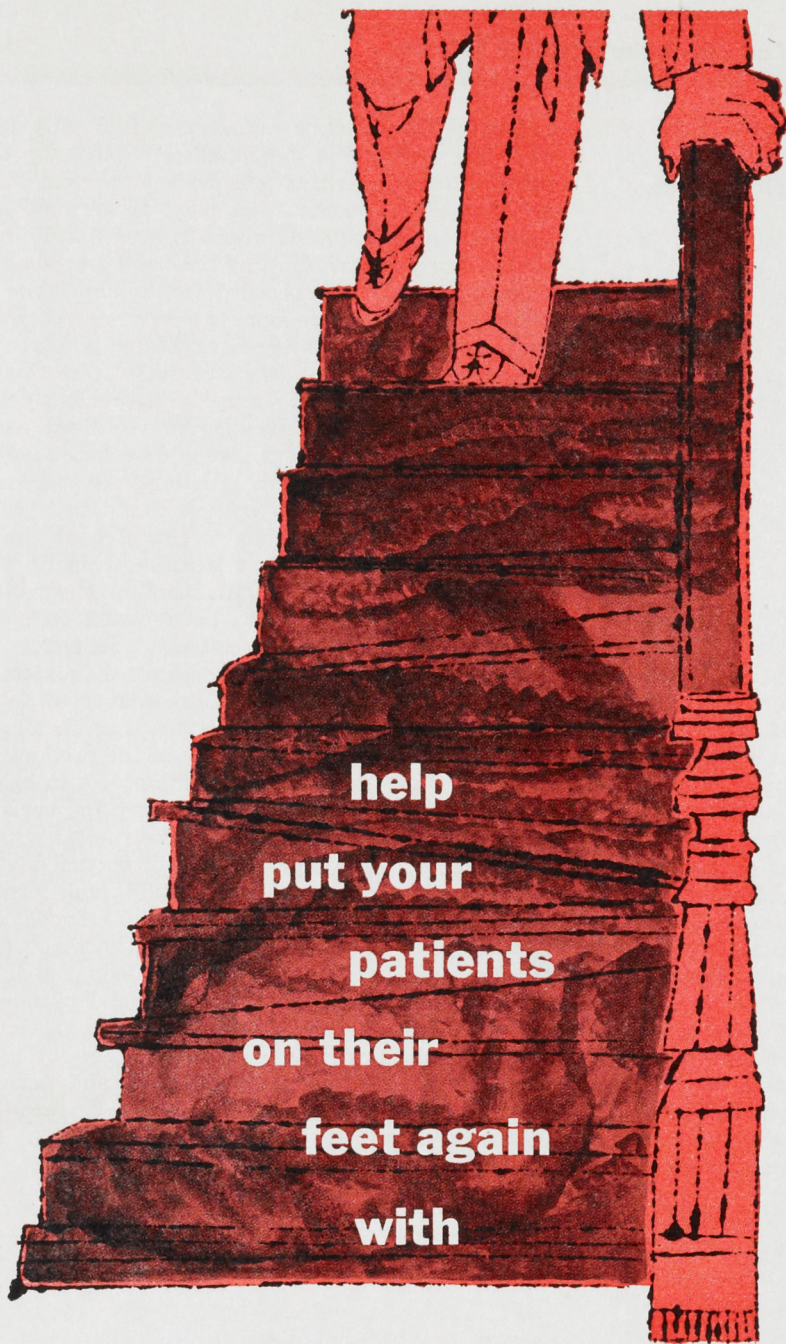
Dr. Ferguson: You always use them, but I am not certain that they are of any special value.

Dr. Grant: Is it worthwhile sending to Montreal for Russell Viper Venom or borrowing Cobra Venom as we had to do here?

Dr. L. Israels: I don't agree with Dr. Ferguson about the local application of thromboplastic agents which I feel can be of considerable value. McFarlane of Oxford is enthusiastic about both the ones already mentioned and he thinks purely local therapy is often sufficient in itself. I think that such a procedure as tooth extraction should always be done with the resident house physician working closely with the dentist because there often is a normal clotting time, following tooth extraction and they seem to be fine, with no evidence of bleeding. Sometimes they will begin to bleed 12 or 24 hours later. Russell Viper Venom has to be applied very carefully touching all raw areas.

I would also like to say something about the diagnosis in this instance. With the data available,

naturally the question comes up as to why this boy was labelled a hemophiliac. Most of the recorded clotting times are close to normal (Lee White). On the other hand most of the bleeding times are prolonged. It would appear that he has then, a fairly normal clotting time and a prolonged bleeding time. The recorded prothombin time is of no particular value since we have no recorded control, and that time is not expressed as percent. One of the things that one can make from this is that the length of the bleeding time depends a great deal on the technique used, a standardized technique is not necessary, but it should be done several times on the same patient. Furthermore there are many hemophiliacs who will be found to have a fairly normal clotting time twenty-five or thirty percent of the time. That leads us back to the question of diagnosis and justification for calling him a hemophiliac. It has been stated that the thromboplastin generation test was abnormal. In the first stage of coagulation you have the platelets, anti-hemophilic globulin and Christmas factor (also known as PTC) (and possibly another factor as well), all of which are necessary in the production of thromboplastin. Our investigation was, in brief, as follows — taking into consideration the various factors one attempts to find out the rate at which thromboplastin is generating. With normal platelets, normal anti-hemophilic globulin, and normal Christmas factor, the time is about 10 seconds. So then we took the patient's platelets, normal AHG and normal Christmas factor and again the time was 10 seconds. Then we took normal platelets, normal AHG and the patient's Christmas factor and again the time was 10 seconds. When we took normal platelets, the patient's AHG, and normal Christmas factor the time was about 60 seconds. So the defect here is pin-pointed at the AHG. He is then in fact a true hemophiliac.



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Editorial

Guest Editorial by S. Vaisrub, M.D., M.R.C.P. (Lond.), F.R.C.P. (Can.), F.A.C.P.

Baskets of Silver

"Apples of Gold" is the title of the last essay published by the late Dr. J. C. Hossack in the August-September, 1954, issue of the Manitoba Medical Review. The glittering title seemed to challenge the imagination. As the eye lingered over the shining words, the mind speculated on their symbolic meaning, and wondered what was in store for it in the pages to follow.

What did the apples allude to? Obviously not to the fruit of the Tree of Knowledge, for the Apple that tempted Eve was a real apple more inviting to the palate than to the eye. Could it be a reference to the golden Apple of Discord, thrown by Eris into the banquet hall of Peleus, the apple that led to the famous judgment of Paris, and the Trojan War? Or was it, perhaps, an allusion to the Golden Apples of the Hesperides, the apples that grew on golden branches with golden leaves, and were so closely guarded by the daughter of Atlas, that no mortal could touch them, no mortal, that is, except Hercules, who attained the seemingly unattainable in his Eleventh Labor? Or are these, perhaps, the three golden apples given by Aphrodite, to Melanion to help him trick Atalanta into marriage? Fair Atalanta, beautiful and "fleet of foot," the "pride of the Woods of Arcady," bent upon remaining free and unattached, winning race after race from unhappy suitors, who had to outrun her in order to win her hand, tricked by three golden apples, thrown at her feet by the wily Melanion. Had she but resisted the temptation to stop and pick them up, she would have won this race too, and remained virginal to the sorrow of Melanion and all those who love a lover, and enjoy a charming story with a pointed moral.

Somehow, none of these fanciful a priori speculations appeared to provide the right answer. The Apple of Discord could be dismissed at once, for nothing but accord and harmony ever emanated from the pen of the writer of "Apples of Gold." The ponderous moral of the Eleventh Labor of Hercules, that of Herculean effort required for the task of attainment, seemed out of keeping with the personality of J. C. H., who carried his heavy learning lightly and gracefully. Nor did the moral of the story of Atalanta, that of the perils of distraction by glitter and beauty when pursuing one's goal quite fit the man, who never permitted true beauty to stop distracting him.

What, then were the "Apples of Gold"? The answer is there on the second page of the essay. One might have guessed it. It is a quotation from Horace. "Words fitly chosen are like apples of gold in baskets of silver." Taking this quotation as one would a lighted candle, J. C. H. guides the

reader from paragraph to paragraph through pages of beautiful prose, illuminating dark alcoves, lighting obscure corners. Gracefully and gently without pomp and pretence he introduces the reader to the world of good books and great men who created them. He speaks quietly of content and style, of matter and manner, of substance and form, of "instruction and delight." He acquaints the reader with the technique of artistic creation, with the artful complexity underlying the seemingly artless simplicity of good writing. He urges the reader to read and read more for "who would express himself well, must read well — and much," for "the reading of books what is it but conversing with the wisest men of all ages and all countries, who thereby communicate to us their most deliberate thoughts, couched in good expression and digested in exact manner "Apples of gold in baskets of silver."

It would seem that in this essay, Dr. J. C. Hossack, the master essayist, has brought the reader, without attempting to be philosophical, closer to the edge of his philosophy of life, than in any other of his short masterpieces. As if anticipating that this would be his last effort, he bequeathed to us all the "World of great minds."

The apples of gold are still here, but the Master Maker of silver baskets to keep them well arranged and well displayed is no longer with us.

In pace requiescat.

Editorial Committee Manitoba Medical Review

A meeting of Executive of the Manitoba Medical Review was held on September 9th, 1954, with the following members attending:

1. S. S. Peikoff, Chairman.
2. M. T. Macfarland.
3. L. A. Sigurdson.
4. Ruvin Lyons.
5. R. H. McFarlane.
6. Mr. J. Gordon Whitley, Business Manager.

Important issues pertaining to the future of the Review and matters of general policy were discussed in detail.

I. Desirability of the Publication

Two pertinent questions were broached for discussion and evaluation.

1. Is there a need for a publication such as the Review?
2. May we delete the scientific portion to advantage?

The general consensus of opinion was that in spite of the superabundance of medical journals, annuals, etc., stemming from every conceivable scientific avenue, there is a definite place for a

smaller provincial periodical which caters to a more modest and less specialized reading personnel generally. The Review tends to cement the local medical group by creating personal relationship and becomes a forum for exchange of ideas on a more intimate level. Social news, items of local interest, local research projects, reviews and reports of clinical and pathological conferences and case histories, have an appeal that is lacking in larger impersonal publications.

The scientific contribution is just as desirable as the social or business aspect. The value of any paper is not necessarily proportionate to the size of the centre where it originates. The calibre and status of the medical men in this province are equal to any on the continent. Their scientific presentations are so much more interesting and palatable since the readers are personally and intimately acquainted with the writers. It must also be remembered that it is the scientific portion which is the direct revenue to the extent of \$12,000.00 per annum from pharmaceutical houses which submit their advertising based on the quality of the scientific contributions.

II. Organization of the Executive

The editor himself cannot replace the entire executive as has been the practise in the past. At this point I wish to pay the greatest tribute to the late Dr. J. C. Hossack, past editor, and to Mr. Whitley, Business Manager, on their success in creating and maintaining for us a publication of which we may all be proud, especially so, when it was achieved under great difficulties due to lack of co-operation from the general medical body.

It was felt that the Executive consist of:

1. An Editor in Chief.
2. Honorary Consultants (appointed by the Editor).
3. An Editorial Board representing a cross section of various fields of medicine and its various departments including related professions, such as University personnel and perhaps legal representation.

The business aspect of medicine must be proportionately represented in all its aspects, e.g., C.M.A., Winnipeg Medical Association, M.M.S., W.C.B., Insurance, Coroner, etc. The faculty of medicine must play the leading role by mustering the various departments, perhaps, according to the ten blocks proposed by the M.M.S. This organization can be planned and integrated by the Editor, but we plead for co-operation on his behalf.

III. Collection and Source of Material

The supply of material to the Review must of necessity be the responsibility of the entire profession. There must be a continuous inflow of material in order that a sizeable reserve may be constantly available. This should be properly organized by the Editor so that the various sources can be tapped continually and the material filed

away in reserve to enable a back-log of at least one year. This material can then be arranged and sorted and then the monthly articles in the Review would represent various departments with at least a semblance of proportion. This procedure would obviate panicky situations such as have arisen in the past when a deadline of material at the publication deadline has resulted in adding burdens and humiliation to the business manager.

Collection of material must be systematic. Heads of various departments ought to be held responsible for continually furnishing papers and contributions from all available sources, and if so, impress their assistants with the importance of at least one contribution a year to the Review. It was felt that an appeal be made to the Dean of Medicine to stimulate students to make contributions to the Review. An incentive might be provided by allotting a nominal credit to the student submitting papers of a reasonable calibre. This procedure, if adopted, would give the students an excellent opportunity to develop skill and ability in reporting case histories accurately and concisely. Such facilities are tragically lacking at the moment. Senior Residents should be held responsible for reporting accurately the essential clinical conferences at luncheons or ward rounds.

It may be desirable to institute a practice of advising speakers at any medical forum, lecture, convention, or gathering, to have a copy of their talk immediately available for publication since experience has shown that procrastination eventually leads to barren results.

IV. Nature of Editorial Policy

The editorial policy of the Review came under discussion.

It was decided that the editorial policy relating to business matters should reflect the views of the M.M.A. and be subject to the control of the M.M.A. It becomes imperative then that the Executive of the M.M.A. furnish the Editor with pertinent information. The Editor must of necessity attend the meetings of the Executive in an ex-officio capacity so that he may acquaint himself with the various problems involved. In matters not relating to business the Editor must be accorded the right of free and independent expression.

V. Appointment of an Editor and the Terms

It was recommended that an Editor be appointed for a period of one year with the option of termination of the contract by either party at the end of the term. Although the exact figure of the honorarium was left to the discretion of the Executive it was felt that the present remuneration was inadequate to compensate for the work entailed if his duties are to be adequately executed. An increase in the honorarium is recommended.

Considerable time was spent by the Executive on the matter of an actual selection of an Editor. It was felt that an immediate appointment would be preferable to a delayed search by advertising for

an applicant. Delay at present would tend to disrupt its present efficient and smooth performance and create innumerable difficulties of readjustment at a future date. It was agreed however, that applications be invited by the Medical Review for the position of Editor in the more remote future if and when deemed advisable.

The following names were suggested by the members of the Executive for consideration:

Dr. Alvin T. Mathers	Dr. Marjorie Bennett
Dr. J. D. Adamson	Dr. S. Vaisrub
Dr. Rawson	Dr. L. A. Sigurdson
Dr. Athol Gordon	Dr. C. H. Walton
Dr. Murray Campbell	Dr. Ross Mitchell
Dr. Graham Pincock	Dr. S. S. Peikoff
Dr. I. McLaren Thompson	

Criteria for selection were discussed in detail on the following basis:

1. Compatibility with the business manager.
2. Age.
3. Ability to organize and co-ordinate.
4. Professional background and writing ability.
5. Willingness to accept terms of office with implied devotion of time and effort and acceptance of rather small honorarium.

Dr. R. H. McFarlane proposed and sponsored Dr. S. Vaisrub as a suitable applicant in accordance with the above requirements. After careful consideration and debate Dr. S. Vaisrub was unanimously recommended.

Manitoba's Medical Men

X. Manitoba Medical Review

When a man dies those that remain have the task of filling his place if his work was of importance to the group. In some cases this is very difficult. The editor of the Manitoba Medical Review died recently. Under his direction the Review became one of the very best provincial medical journals, not only a good scientific journal but also a good medium for local medical problems.

With the death of the editor, the Executive had several problems to contend with. The first of these was whether the journal should be continued in its present form or whether changes were necessary. The second problem was the selection of a successor. This proved no easy task. About a dozen names were submitted for consideration. Due to the importance of the post, the Executive decided to wait and consider the matter with great care. Under these circumstances the associate editor and editorial board were prevailed upon to fill in the gap until a new editor could be chosen. This seemed a wise decision in view of the fact that the Review acts as a tie between the doctors of the province who have to work in widely scattered areas with very little contact with other members of the profession and this link must be maintained.

L. A. Sigurdson, M.D.

Obituary

Alfred Cox, M.A., M.D., O.B.E., LL.D.

The British Medical Journal reports the death on August 31st of Dr. Alfred Cox, 88, former Secretary of the British Medical Association, after a long and painful illness.

Many of the older members of the Manitoba Medical Association will hear this news with regret. Although British as his name and a true North countryman, Dr. Cox had ties with Canada and Manitoba. He visited Winnipeg twice. In 1924 our Association invited the British and Canadian Medical Associations to hold a joint annual meeting in Winnipeg. The British Medical Association sent out Sir Jenner Verrall and Dr. Cox to investigate and report. They were present at our annual meeting in 1924 and addressed a public meeting in the old Congregational church on "Britain's War Effort." The invitation was accepted for 1930 and Dr. Cox was one of the British guests. At the dinner held in Hudson's Bay store he was presented with a statue of a bronze buffalo in appreciation of his efforts in making the meeting possible, and was also made a life member of the Manitoba Medical Association. The University of Manitoba at a special convocation conferred the LL.D. degree on several distinguished medical men, among them Dr. Cox. These honors he greatly cherished. He read the Review regularly and when in 1951 he showed me through the B.M.A. House, he pointed out the Review in the reading room of the Library, and also the flag of Winnipeg hanging in the Great hall in company with the flags of other cities in which the Association had met. He kept in touch with medical developments in Manitoba. An ideal correspondent, he could always be relied on for wise counsel.

In 1950 his autobiography appeared under the title "Among the Doctors." It was the very human document of one who came into medicine in his own words "through an obscure back door now closed," as a medical assistant, and after practising as a general practitioner in Gateshead, became in 1911 Secretary of the British Medical Association. He guided the Association in the negotiations with Lloyd George over the National Health Insurance Act, and through the first World War. In 1925 he visited South Africa and effected a merger of two rival medical associations.

His last illness revealed the true measure of the man. His medical advisers, among whom were Lord Horder and Sir Stanford Cade, did not reveal to him that he was suffering from cancer. He may have suspected it but he jestingly referred to the pain in his hip as "coaxalgia," never was despondent and wrote for the British Medical Journal book reviews and obituaries of his old friends almost to the day of his death.

Ross Mitchell.

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ELIXIR B-COMPLEX, WYETH

... better than ever!

NEW... B-Plex is now derived from two natural sources—rice bran concentrate and yeast—known to be two of the principal sources of the vitamin B-Complex.

IMPROVED... Each teaspoonful of B-Plex now contains 2.075 mcg. Vitamin B₁₂—important in growth stimulation and blood formation and in overcoming fatigue.

BETTER THAN EVER... The new B-Plex has a highly improved taste—exceptionally pleasant to take. B-Plex provides adequate and complete vitamin B-Complex therapy in a pleasantly flavoured, elixir type base.

CHECK THE ^{new} FORMULA!

Each teaspoonful contains Vitamin B-Complex as derived from 0.2 grams aqueous extract of rice bran and yeast and provides:

✓ Thiamine.....	.625 mg.
✓ Riboflavin.....	1.250 mg.
✓ Niacin and Niacinamide.....	6.250 mg.
✓ Pyridoxine.....	.625 mg.
✓ d-pantothenic Acid.....	3.125 mg.
✓ Vitamin B ₁₂	2.075 mcg.

DOSAGE: 2 to 6 teaspoonfuls daily as prescribed by the physician.

Note!

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Social News

Reported by K. Borthwick-Leslie, M.D.

Dr. and Mrs. J. M. Woods, Karen and Brian bade Dauphin a fond farewell early in the fall, transferring to 91 Durie Street, Toronto, Ont. Dr. Woods is doing post-graduate work in surgery at the U. of T.

Thanks for the kind words doctor, re the column.

The Manitoba Clinic welcomes to its staff Norman Dryburgh McCreath, M.R.C.P. (London), M.D.A.C.P., who will practice Internal Medicine with gastro-enterology as his special interest. Welcome to Winnipeg, Dr. McCreath.

Lloyd C. Bartlett, M.D., F.R.C.S. (C.), announces the opening of his office at 401 Medical Arts for the practice of General Surgery.

Percy Barsky, M.D., announces the opening of his office at 1471 Main St., Winnipeg. Paediatrics only.

Briefly around the world with some of our other graduates:

Donald M. Black '24, is now in Kamloops, B.C., with the South Central Health Unit.

Cecil B. Sheps '36, has been appointed lecturer in preventive medicine at Harvard Medical School.

Quentin D. Jacks '40, who is now completing his post-graduate work at Mayo's, plans on migrating to Vancouver, specialty, Otolaryngology.

Casimer T. Wolan '41, has been awarded a Research Fellowship to continue his studies in Cancer at Columbia University.

D. E. Bergsagel '49, has been granted a Medical Research Fellowship to study at Oxford University.

A. Malkin '49, has also been awarded a Medical Fellowship to study at McGill.

Dr. and Mrs. Arnold Rogers, with Susan, are at present guests of Mrs. Roger's parents, Niagara St. Dr. Rogers has been three years with Mayo's, but they plan to make their home in Winnipeg.

Dr. and Mrs. H. D. Kitchen attended a re-union of ex-resident physicians of the Mayo Clinic at Rochester.

Too many V.I.P. were elected, wine, danced, etc., at the highly successful Convention in October to be mentioned individually, but I cannot resist commenting on Jack McKenty's "Churchillian Address" (quote Bill Boyd).

Good organization, Jack, efficiently and entertainingly reported.

Dr. Lois Hokanson, eldest daughter of Capt. and Mrs. Hokanson, Lockport, Man., July 12, 1954, became the bride of Michael Jamemko. Dr. Lois is a 1952 graduate from the Manitoba Medical College, and is now located at Brookdale, Man.

August 25, 1954, Dorothy Fainstein, a 1954 graduate of the Winnipeg General Hospital, became the bride of Dr. Daniel Shapiro, a 1954 graduate from the University of Manitoba Medical School. Dr. and Mrs. Shapiro will reside in Winnipeg.

September 17, 1954, Louise Overall, a '51 graduate of the Winnipeg General Hospital, became the bride of Dr. Ian Donald MacLeod, a '53 graduate of Manitoba Medical College.

Dr. and Mrs. J. Margolis announce the birth of a daughter, October 7th, baby sister for Rachel and David.

Dr. and Mrs. E. A. Osberg are happy to report the birth of Eldin Gladys, sister for Desley and Ted.

Dr. and Mrs. Guthrie Grant (nee Joy Bedson) report the arrival of Elenor Jane, at Oshawa, Oct. 2, 1954.

Dr. and Mrs. M. Broder announce the birth of Anita Leach, Oct. 20, 1954, a sister for Harley Joel.

Dr. and Mrs. Robert F. Burns, Carrington, N.D., are happy to announce the birth of their second daughter, Tannis Claire, Sept. 30, 1954.

Dr. and Mrs. Colin Ferguson, announce the arrival of a son, September 20, 1954.

Dr. and Mrs. Barney Seeter welcome their daughter, Mita Barbara, September 11, 1954.

Percy Barsky, M.D., announces the opening of his office at 1471 Main Street, Winnipeg—Pediatrics only.

Dr. Lois Hokanson, eldest daughter of Capt. and Mrs. Hokanson, Lockport, Man., July 12, 1954, became the bride of Michael Jamemko. Dr. Lois is a 1952 graduate from the Manitoba Medical College, and is now located at Brookdale, Man.

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Though only a temporary visit back home, it was a pleasure to see our old friend Dr. George Wakefield, wife and four children, who are now situated in Vancouver. George, for sure, has lost a lot of weight, could be those four youngsters keep him somewhat more active than he used to be in the army!!

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"Beminal" with phenobarbital

Your prescription supplies

- appetite-stimulating vitamins ● mild sedation for the nervous patient

Each Tablet No. 819 provides:

Thiamine	5	mg.
Riboflavin	2	mg.
Niacinamide	10	mg.
Pyridoxine	0.5	mg.
d-Panthenol	2	mg.
Ascorbic Acid	25	mg.
Vitamin B ₁₂ Crystalline	1	mcgm.
Phenobarbital	(1/4 gr.) 16	mg.

"Beminal" with Phenobarbital Liquid, No. 922, has a similar formula but contains d-Desoxyephedrine Hydrochloride, which imparts a gentle emotional uplift.



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1954

COMMITTEE REPORTS

Manitoba Medical Association

(Canadian Medical Association, Manitoba Division)

Executive

*To the Executive Committee and Members of
The Manitoba Medical Association:*

1.

It is a distinct privilege to welcome guests and members to the forty-seventh annual meeting of the Association. This is the last of a series of western divisional meetings of the Canadian Medical Association and a hearty welcome is extended to the President, Dr. G. F. Strong of Vancouver, and Assistant Secretary, Dr. A. F. W. Peart of Toronto. The Scientific Program Committee under the capable leadership of Dr. T. A. Lebbetter has planned a good program and guest speakers from beyond the province will be Doctors Richard Day, New York; John H. Moore, Grand Forks, N.D.; D. S. Munroe and Roger Wilson, Vancouver; E. M. Nanson, Saskatoon. Brigadier J. N. B. Crawford, Ottawa, will address a noon luncheon of the Defence Medical Association and a special speaker will address a dinner meeting of the General Practitioners' Association.

This report covers the activities of the Association year 1953-1954 during which there have been eight regular meetings of the Executive with an average attendance of seventeen members and an additional three invited participants. Through the generosity of the Board of Trustees, Manitoba Medical Service, the facilities of the Board Room and Cafeteria have been made available to the Association for the Executive Committee meetings.

The Association extends fraternal greetings to the groups which met during the past week in conjunction with the Western Hospital Institute.

The College of Physicians and Surgeons of Manitoba meets in Annual session on October 16th. C.A.M.S.I. meetings are being held simultaneously during the present week, and will be followed next week by the Association of Canadian Medical Colleges and the Royal College of Physicians and Surgeons of Canada.

Canadian Medical Association

2.

The site for the 87th Annual Meeting was Vancouver, and a more delightful setting with salubrious climate would be difficult to find. The dates were June 11th to 18th inclusive — Executive Committee met June 11th and 12th — General Council 14th and 15th — Annual General Meeting June 16th — and Scientific Program June 16th to 18th.

The host was the British Columbia division which had nominated Dr. G. F. Strong as President-Elect for the year 1954-55, and in addition to a reception for Council members on June 13th, the main social events for members and ladies were the dinner to General Council on June 15th, the President's reception and dance on June 16th and a twilight cruise on June 17th.

One feature of the business session was the elevation of Dr. T. C. Routley from the position of General Secretary, a post which he has filled most creditably for the past thirty-one years, to that of President-Elect of the Association. In that capacity he will preside over the 1955 annual meeting of the Association to be held in Toronto in conjunction with that of the British Medical Association of which he has also been named President-Elect.

The Manitoba Division was represented in General Council by Drs. A. M. Goodwin, J. E. Hudson (Hamiota), M. T. Macfarland, J. McKenty, H. L. McNicol (Flin Flon), F. H. Smith, C. B. Stewart, W. F. Tisdale, R. W. Whetter (Steinbach). Were it possible to name representatives earlier in the year the effectiveness of the delegation might be increased.

Dr. Arthur D. Kelly was named to the post of General Secretary and Dr. Arthur F. W. Peart, that of Assistant General Secretary. Dr. S. S. B. Gilder was appointed co-editor of the Canadian Medical Association Journal which, in 1955, will be published twice monthly.

Toronto was selected as the future permanent home of the Association, and arrangements for the consolidation were placed in the hands of the Executive Committee.

At the Annual General Meeting held on Wednesday, June 16th, the chain of office was passed from President C. W. Burns to President-Elect G. F. Strong. Life membership was conferred on representatives of the ten Divisions including Dr. Murdoch MacKay, Transcona. The presentation of a silver tea service to Dr. and Mrs. Routley was an event of great interest.

One of the outstanding features of the week was the inauguration of the College of General Practice on June 17th and the dramatic presentation by Dr. T. C. Routley to the President, Dr. M. R. Stalker of a gavel fashioned of wood from the Island of Cos.

A complete report of the Business Meeting appeared in the September issue of the Canadian Medical Association Journal, perusal of which is recommended to all members.

Advisory Commission Under the
Health Services Act

3.

Three representatives on the Commission are named by the Association, the present incumbents being Drs. C. Wiebe, D. L. Scott, and W. F. Tisdale. The Executive Committee invited Dr. Wiebe to represent the Association for a further three year term.

Cancer Relief and Research Institute

4.

The Association names three representatives, one of whom retires each year. These constitute the Cancer Committee of the Association, and Dr. O. Burrell was the new appointee.

Civil Defence

5.

With changing emphasis at the federal, and changing personnel at provincial and local levels, general interest in civil defence is difficult to obtain or retain. The Winnipeg Medical Society deserves commendation for the manner in which important planning has proceeded.

District Medical Societies

6.

A feature of the meetings which have been attended by the President and Executive Secretary has been the continuing interest in the business and scientific aspects. Attendance has been good, and the proceedings of the Executive Committee have been received by the district representatives and relayed to the membership.

The Education Committee has studied and made proposals for holding clinical days at various hospital centres during the year. The proposals have been approved in principle by the Executive Committee, and concurrence of the District Societies is now being sought.

Manitoba Medical Review

7.

The passing of Dr. J. C. Hossack on August 16th marked the end of a period during which the Review had developed into one of the foremost provincial publications. The article "Apples of Gold" under Fugitive Pieces in the August-September issue received favourable comment from many readers.

Dr. S. S. Peikoff, Associate Editor, accepted the responsibility of directing the publication until policy has been decided and a new Editor selected.

Manitoba Hospital Service Association

8. At the request of the Executive Director a committee was named to advise upon the procedures for which M.H.S.A. coverage might be provided, and another committee was named to adjudicate upon borderline claims.

The Psychiatric Section of the Association had already negotiated successfully for a more liberal interpretation of the regulations for psychosomatic conditions.

Limitation of Hospital Privileges

9. In the effort to qualify for accreditation, some hospitals have made regulations which may be more restrictive than formerly. The Executive considered the possible effects of such regulations and formed a committee with teaching, specialist and general practitioner representatives to confer with the medical staff or hospital board.

Municipal Contract

10. During the year various anomalies in the standard contract were brought to the attention of the Executive and were discussed with the representatives to the Advisory Commission under the Health Services Act, which body has also been concerned with a revision of the salary schedule which has remained unaltered since the inception of the plan.

Medical History

11. For many years Dr. R. B. Mitchell has been the devoted correspondent for this Division to the Canadian Medical Association Journal and has made an outstanding contribution to our provincial publication of which he was editor. Always interested in history, Dr. Mitchell has now written an outline of medical history in Manitoba which is to be published. The Executive has given consideration to the project and will determine to what extent assistance will be given by the Association.

Membership

12. It is a pleasure to acknowledge the support of a record number of members. A classification of membership with fees applicable to each class was received from the Canadian Medical Association which was effective for 1954. The increased fee has been remitted to the Canadian Medical Association on behalf of salaried employees without a corresponding increase in the annual fee charged. This matter will be considered by the incoming Executive.

Specialist Status — M. M. S.

13. The joint committee consisting of representatives of this Association and the Manitoba Medical Service recommended to the respective bodies that a practitioner whose name was enrolled on the Specialist Register maintained by the College of Physicians and Surgeons of Manitoba should be so recognized by Manitoba Medical Service.

Doctors' and Nurses' Directory

14. Dr. F. G. Allison was invited to represent the Association on the reorganized governing board of the above directory.

Committee on Nursing

15. Dr. A. M. Goodwin was selected as chairman of a committee to work in conjunction with the Associated Hospitals of Manitoba and the Manitoba Association of Registered Nurses to study effective methods of providing adequate nursing personnel.

Ethics

16. A question frequently raised is whether or not a member of the Association should seek permission from his district society, if requested, to address a lay audience. The reluctance of the private practitioner to transgress the code must often be balanced against the legitimate demand on the part of the public for information, and the enlightened attitude of the profession towards public relations. The Canadian Medical Association has adopted the following revision under communication to the laity on medical subjects, "when an official body of organized medicine finds it necessary to ask a medical practitioner to make a statement for the public and decides that the circumstances make it necessary that his name be attached to it, the medical practitioner shall be absolved from criticism in so doing."

Manitoba Medical Association Medal University of Manitoba

17. A medal is awarded annually to the student who obtains the highest standing in the first four years of the medical course. Negotiations were carried out to have the wording inscribed on the medal correspond with the actual conditions of the award.

Manitoba Medical Service

18. Nominations were provided at the last annual meeting. A mailed ballot was taken and results were tabulated under the proportional representation system by experienced personnel. The nominations were accepted by Manitoba Medical Service, and members were installed at the Annual Meeting on March 16th. A dinner arranged by Manitoba Medical Association complimenting the lay members of the Board and retiring medical members including Dr. P. H. McNulty was held the same evening. Manitoba Medical Service has become a big factor in the economic life of the profession, and Dr. P. H. T. Thorlakson, Chairman of the Board, will be present to discuss the Manitoba plan at the evening business session.

Memorial to Graduates Who Lost their Lives In World Wars I and II

19. Participation of the Association in this project was approved in principle and a letter to this effect forwarded to the Dean, Faculty of Medicine, University of Manitoba. Following discussion by the Faculty Council the matter was referred to the Board of Governors.

Pension

20. At the last Annual Meeting methods of providing financial security for members of the profession which might eliminate the need for a benevolent fund were proposed.

Considerable activity ensued the negotiations including the Group Insurance and Pension Committee and Manitoba Medical Service. A more detailed report will be presented under the appropriate headings.

Response to a questionnaire by the profession concerning car insurance was good, but unless there is common ownership of automobiles, there is a legal barrier to fleet coverage.

Public Relations

21. The report of this Committee will outline steps taken to improve public relations. Manitoba Medical Service agreed to share the cost, but elected not to use the broadcast for promotional purposes.

Employment of a public relations counsel on a part or whole time basis was considered.

Although no formal grievance committee has been established many matters are handled directly by the Executive Secretary through the Association office.

Rehabilitation

22. Evidence of the increasing importance of this subject since government is undertaking to pay pensions to disabled persons, is the establishment by the Canadian Medical Association of a Standing Committee on Rehabilitation. This Division is asked to make a similar appointment.

At a meeting convened by the Minister of Health on June 24th an outline was given of the activities of the provincial committee with Mr. Boyd as co-ordinator. A representative of this Association has been moved by the provincial government to act on the departmental committee.

Royal Commissions

23. The Psychiatric Section presented briefs on behalf of the Association to two Royal Commissions in Winnipeg on August 31st to consider insanity as a defence in criminal cases, and the criminal law relating to sexual psychopaths.

Secretaries' Conference Canadian Medical Association

24. In February, 1954, the provincial secretaries met in Toronto for two days to consider matters of importance to the Divisions and the Canadian Medical Association. Entertainment was provided at the home of Dr. and Mrs. T. C. Routley on the first evening, while members were invited to dine with the Public Relations Committee the following evening, and to join in the deliberations of that committee.

Victorian Order of Nurses

25. Dr. M. H. Campbell was again named representative to the federal board of the above order.

The accompanying reports will indicate the various facets of the Association activities.

It is a pleasure to acknowledge the co-operation received from the members of the many committees and groups during a year which has been busy and interesting.

W. F. Tisdale,
President.

J. E. Hudson,
Honorary Secretary.

Finance

26. Winnipeg, Manitoba,
10th March, 1954.

To the Members,
Manitoba Medical Association,
Winnipeg, Manitoba.

Dear Sirs:

We have examined the Statement of Assets and Liabilities of the Manitoba Medical Association as at 31st December, 1953, and the Statement of Revenue and Expenditure for the year ended on that date. Our examination included such tests of accounting records and other supporting evidence as we considered necessary in the circumstances and we have obtained all the information and explanations we have required. We submit herewith the undernoted financial statements:

EXHIBITS:

"A" Statement of Assets and Liabilities as at
31st December, 1953.

"B" Statement of Revenue and Expenditure for
the year ended 31st December, 1953.

The operations for the year, as set forth in Exhibit "B," have resulted in an excess of revenue over expenditure of \$7,623.39. Membership fees collected are in accordance with duplicate receipts on file and were reconciled with membership cards issued. The Association also received the customary sums, covering applicable portions of the general office expenses, of \$80.00 per month from the College of Physicians and Surgeons for the year, and \$100.00 per month from the Winnipeg Medical

Society, until 1st November, at which time this amount was increased to \$110.00 per month. All expenditures have been properly authorized.

Relative to our examination of the various items comprising the Statement of Assets and Liabilities, marked Exhibit "A," we have the following comments to make:

CASH ON HAND AND IN BANK, \$2,451.38: We did not count the cash shown to be on hand. Subject to an allowance for outstanding items as shown by the books, the amount shown to be on deposit is in agreement with a certificate received from your bankers.

ACCOUNTS RECEIVABLE, \$1,345.51: Of this amount \$107.30 remained outstanding at the date of this report. All accounts are considered to be collectible in full.

INVESTMENTS, \$23,132.12: During the year your holdings were increased by the acquisition of the following bonds:

	Par Value	Cost
British Columbia Electric Co. Ltd., 4¾%—1st December, 1977.....	\$ 2,000.00	\$ 2,005.00
Hydro Electric Power Comm. of Ontario, 4¼%—15th July, 1969.....	2,000.00	1,997.50
Province of New Brunswick, 4½%—15th July, 1969.....	4,000.00	3,970.00
Province of Manitoba, 4¼%—1st October, 1968.....	5,000.00	5,087.50
	<u>\$13,000.00</u>	<u>\$13,060.00</u>

We examined the bonds and found them to be in order, duly registered in the name of the Association. All bond interest has been accounted for, on a received basis, in the accounts of the Association.

Subject to the foregoing comments we are of the opinion that the accompanying Statements of Assets and Liabilities and of Revenue and Expenditure are properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Manitoba Medical Association as at 31st December, 1953, and the result of its operations for the year ended on that date, according to the best of our information and the explanations given to us and as shown by the books of the Association.

In conclusion we wish to express our appreciation of the co-operation given us during the course of our work.

Yours very truly,
THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

Exhibit "A"

27. Statement of Assets and Liabilities as at 31st December, 1953

ASSETS

Current Assets:

Cash:

On Hand—petty cash.....	\$ 20.00
In Bank of Montreal.....	2,431.38
	<u>\$2,451.38</u>

Accounts Receivable:

Review Advertisers.....	\$ 759.65
College of Physicians and Surgeons:	
Extra-Mural Expenses.....	62.65
Winnipeg Medical Society.....	120.00
Advance—J. G. Whitley.....	403.21
	<u>1,345.51</u>
	<u>\$ 3,796.89</u>

Investments:

(Market Value \$22,641.00)

Bonds:

Province of Manitoba:	Par	Cost
4½% 1956.....	\$ 2,000.00	\$1,957.12
3% 1968.....	2,000.00	1,965.00
4¼% 1968.....	5,000.00	5,087.50

Province of New Brunswick:		
4½% 1969	4,000.00	3,970.00
Government of Canada:		
3% 1957	1,000.00	1,000.00
3% 1959	500.00	500.00
3% 1963	500.00	500.00
3% 1966	4,000.00	4,150.00
Hydro Electric Power		
Commission of Ontario:		
4¼% 1969	2,000.00	1,997.50
British Columbia Electric		
Co. Ltd.:		
4¾% 1977	2,000.00	2,005.00
		23,132.12
	\$23,000.00	
Office Furniture and Equipment		
	\$2,102.30	
LESS: Reserve for Depreciation		
	2,102.30	
		\$26,929.01

LIABILITIES

Current Liabilities:		
Canadian Medical Association:		
Unremitted Fees	\$ 20.00	
Fees collected in advance	52.50	
		\$ 72.50
Surplus Account:		
Balance as at 31st December, 1952	\$19,233.12	
ADD: Excess of Revenue over Expenditure		
as per Exhibit "B"	7,623.39	
		26,856.51
		\$26,929.01

Exhibit "B"

28.

**Statement of Revenue and Expenditure
For the year ended 31st December, 1953**

REVENUE

Fees Collected:		
513 Members at \$40.00	\$20,520.00	
2 Members at 30.00	60.00	
19 Members at 20.00	380.00	
116 Members at 12.50	1,450.00	
5 Members at 6.25	31.25	
59 Members at 16.65	982.35	
22 Members at 8.32	183.04	
6 Members at 37.00	222.00	
4 Members at 9.50	38.00	
746	\$23,866.64	
ADD: Arrears — 1952		
	40.00	
		\$23,906.64
Winnipeg Medical Society	1,220.00	
College of Physicians and Surgeons	960.00	
Interest on Bonds	160.80	
		\$26,247.44

EXPENDITURE

Salaries:	
Dr. M. T. Macfarland	\$5,000.00
M. Graham	521.00
R. Butler	521.00
Other (Left Service)	3,117.50
	\$ 9,159.50
Expense Allowance—Dr. Macfarland	
	1,200.00
Honorarium — Dr. Hossack	
	1,500.00
Annual Meeting:	
C. M. A.	\$1,144.49
M. M. A.	1,199.40
	2,343.89
Audit Fees	100.00
Business Taxes	150.18
Executive Luncheons	95.95
General Expenses	679.09
Illustrations — Review	149.73
Legal Fees	35.00
Printing, Postage and Stationery	761.27
Rent and Light	1,752.97
Telephone and Telegraph	399.10
Travelling	251.60
Unemployment Insurance	45.77
	\$18,624.05
ADD: Excess of Revenue over Expenditure	
for the year	7,623.39
	\$26,247.44

29.

**Supplementary Statement of Assets and Liabilities
1st January, 1954, to 31st August, 1954**

ASSETS

Cash:	
Petty Cash on Hand	\$ 20.00
Bank of Montreal, Current	3,766.15
Bank of Montreal, Savings	15,000.00
	\$18,786.15
Accounts Receivable:	
Review Advertisers	1,587.78
College of Physicians and Surgeons—	
Extra Mural	328.55
Fee Taxing Committee W.C.B.	35.00
Winnipeg Medical Society	110.00
	2,061.33
Investments	23,132.12
	\$43,979.60

LIABILITIES

Accounts Payable:	
Dr. J. C. Hossack—Honorarium	\$ 1,000.00
Mr. J. G. Whitley—re Review	533.32
Overpayment of Membership Fee	30.00
	\$1,563.32
Deferred Income:	
Annual Meeting—Exhibitors' Deposits	3,687.50
Surplus:	
Balance as at 31st December, 1953	26,856.51
ADD:	
Excess of Revenue over Expenditure	11,872.27
	38,728.78
	\$43,979.60

Statement of Revenue and Expenditure for the period 1st January, 1954 to 31st August, 1954

30.

FEES COLLECTED:		REVENUE		Comparison 1953		Comparison 1952	
		1954					
1/2 year @ \$40.00	578 Members @ \$40.00	\$23,120.00		508 @ \$40.00	\$20,320.00	593 @ \$40.00	\$19,720.00
Salaried	8 Members @ 20.00	160.00		14 @ 20.00	280.00	4 @ 20.00	80.00
1952 grads	95 Members @ 5.00	475.00		1 @ 30.00	30.00	97 @ 15.00	1,455.00
1953 grads	23 Members @ 5.00	115.00		115 @ 12.50	1,437.50	1 @ 7.50	7.50
1954 grads	24 Members @ 15.00	360.00		2 @ 6.25	12.50	49 @ 20.00	980.00
Salaried Combined Fee	13 Members @ 20.00	260.00		58 @ 16.65	965.70	27 @ 10.00	270.00
Combined H. & W.	3 Members @ 8.00	24.00		21 @ 8.32	174.72	6 @ 37.00	222.00
Retired	7 Members @ 43.00	301.00		6 @ 37.00	222.00	2 @ 12.00	24.00
Post-Graduate	6 Members @ 21.00	126.00		4 @ 9.50	38.00		
Non Resident	5 Members @ 20.00	100.00				679	\$22,758.50
	2 Members @ 25.00	50.00		729	\$23,480.42	Plus arrears, 1951	50.00
	8 Members @ 15.00	120.00		Plus arrears, 1952	40.00	Non-resident	12.00
	772	\$25,211.00		Plus 1 change in cat.	17.50		
Plus arrears, 1953		40.00		Plus 1 special non-res.	12.50		
Plus one on account		10.00					
		\$25,261.00					
					\$23,550.42		\$22,820.50

Brought Forward from Fees	\$25,261.00
College of Physicians and Surgeons	640.00
General Practitioners' Association of Man.	89.47
Winnipeg Medical Society	880.00
Bond Interest	616.25
	\$27,486.72

EXPENDITURE

Salaries:	
Dr. M. T. Macfarland, including expense allowance	\$4,800.00
Miss M. Graham	1,281.50
Mrs. R. Butler	1,155.00
Miss E. Armstrong	152.58
	\$ 7,389.08
Honorarium, Editor	1,000.00
Unemployment Insurance	32.88
Rent	1,118.40
Printing, Postage and Stationery	488.85
Printing, Postage and Stationery, Fee Schedule	1,795.00
Telephone	251.95
Executive Luncheons	6.00
Travelling Expenses	284.40
Review Illustrations	215.11
Light	54.37
Bank Charges	16.43
Fees, Complimentary	4.00
Office Miscellaneous Expenses	109.25
Transcription of Records	6.35
Radio Broadcasts	1,613.48
C. M. A. Annual Meeting	80.05
Entertainment Expenses	719.42
General Expense	25.26
Bond on Treasurer	5.00
Servicing Typewriters	39.00
Auditors' Fee	175.00
Business Tax	150.17
Legal Fees	35.00
	15,614.45
	\$11,872.27

31.

Estimated Cost of Operation from 1st September, 1954 to 31st December, 1954

REVENUE

College of Physicians and Surgeons	\$ 320.00
Winnipeg Medical Society	440.00
Bond Interest	300.00
	\$ 1,060.00

EXPENDITURE

Salaries	\$ 4,000.00
Rent	601.20
Unemployment Insurance	15.00
Light	28.00
Telephone	125.00
Printing, Postage and Stationery	200.00
Miscellaneous	150.00
Annual Meeting	2,500.00
	7,619.20
Estimated Deficit for the period	\$ 6,559.20
Excess Revenue over Expenditure	
1st January, 1954, to 31st August, 1954	11,872.27
Estimated Net Excess Revenue for the year 1954	\$ 5,313.07

Membership as at August 10th

To the President and Executive of
The Manitoba Medical Association:

30A.

I wish to present the following report to date:

There are 905 doctors in the Province of Manitoba.

647 Winnipeg	
258 Rural	
768 Active Paid-Up Members	521 Winnipeg
(742 in the Province)	221 Rural
	26 Outside Province
	5 Winnipeg
	9 Senior Members
	4 Rural
1 Complimentary Member, due to ill Health	1 Winnipeg
31 Retired or over 70 years	25 Winnipeg
	6 Rural
122 Membership Fees unpaid	79 Winnipeg
	43 Rural
905	

Of the 122 doctors whose fees are unpaid, 32 are new registrants, 12 are interning in hospitals, 17 are in the Armed Services, 12 are not practising, 1 in ill-health, leaving a potential 48 from whom fees are collectible. On this basis, the percentage of paid-up membership is 94.6.

31 doctors have been lost to the Association during the year, 5 are deceased and 26 have left the province.

54 new members have been enrolled to date this year.

The number of paid-up members is higher by 46 than it was at this time last year. The total membership at the end of 1953 was 750.

Respectfully submitted.

Jack McKenty,
Chairman.

Cancer

To the President and Executive of
The Manitoba Medical Association:

32. At time of printing report of Cancer Committee is awaiting a final meeting of the Medical Advisory Committee of the Cancer Relief and Research Institute and a complete report will be presented at the Annual Meeting.

Respectfully submitted.

Ruin Lyons,
Chairman.

Constitution and Bylaws

To the Executive Committee and Members of
The Manitoba Medical Association:

33. No meeting.
No report.
Respectfully submitted.

Dr. B. E. Loadman,
Chairman.

Credentials and Ethics

To the President and Executive of
The Manitoba Medical Association:

34. I am glad to be able to report that there were no cases referred to this committee during the year. So we must submit a "nil report."

Respectfully submitted.

R. P. Cromarty,
Chairman.

Economics

To the President and Executive of
The Manitoba Medical Association:

35. The Committee on Economics had several study problems presented to them this past year.

First a study was made of the medical care of Social Assistance Groups. In Manitoba these combine the Pension groups, Blind, Old Age, etc. It was found that five provinces have already a method whereby medical care of various degrees is paid for by the state. In most cases the payment is left in the hands of a committee of the profession chosen in various ways and usually approved by the responsible government department.

The Canadian Medical Committee studied this question and had reports from each province. A sample plan was presented by Dr. Lloyd Brown of Regina. It was decided that this is a provincial responsibility that each Division should work out for itself.

Comments on these proposals and some information about the care of the Social Assistance Groups in Manitoba were made to the Minister of Health but were not favourably received. The profession still feel that work done for this fairly large and scattered group of people, should receive some recognition by the public at large and the authorities.

A brief study was made of the "Principles relating to Health Insurance" of 1944 and the "Statement of Policy" 1949.

36.

Our report to the C.M.A. Committee on Economics follows: "In studying the Principles relating to Health Insurance it was pointed out that this document was announced to Canadians and to the Government of Canada to show that the medical practitioners were ready to adopt a plan of contributory prepaid medical care if considered advisable, but under conditions that were fair to those receiving and those giving the services.

"The Principles describe certain conditions and standards which they considered necessary to make such a plan work fairly.

"We consider that these principles with a few minor changes noted below are still applicable to Canadian medical practice.

"Principle No. 5. Instead of "Compulsory for" substitute "Made available to".

"Principle No. 7. Insert "Medical" after transient.

Principle No. 18. Delete as being not applicable.

"We then turned to the Statement of Policy of June 14, 1949. It was readily recognized that this statement briefly reiterated many of the Principles of 1944 and certainly did not seriously change or deny any of them.

"If this was our policy in 1949, and it seemed and still seems to be good policy and recognizes that fairness to all parties is paramount, then there need be no change in this statement.

"It was pointed out that probably the most important paragraph in the Statement of Policy is No. 6 —

"The Canadian Medical Association, having approved the adoption of the principle of health insurance, and having seen demonstrated the practical application of this principle in the establishment of voluntary prepaid medical care plans, now proposes:

- (a) The establishment and/or extension of these Plans to cover Canada.
- (b) The right of every Canadian citizen to insure under these plans.
- (c) The provision by the State of the Health Insurance premium, in whole or in part, for those persons who are adjudged to be unable to provide these premiums for themselves."

The C.M.A. has worked hard to further this statement and this now has reached the T.C.M.P. stage, with which all members of this Committee are more or less familiar."

Revision of Section 3, Paragraph 3 of Schedule 1 of Regulation 27/47.

"This communication dealt with Subsection 3, of Schedule 1, which has to do with the employment and termination of employment of a Municipal Physician. It was pointed out that abuse could be made of this section, in which a physician could be presented with more than one notice of termination of contract in any one year, and also that more than one vote of the ratepayers of the municipality could be called in any one year.

"In going over this paragraph the Economics Committee felt that if a phrase was inserted somewhere in the last line, say, after the word "area", which would read "at the next regular municipal election" or words to that effect, this would make it seem that only one such election could be held in any one year and that this would give to the municipal doctor some semblance of security."

Revision of doctors' contracts in regard to remuneration.

37.

Municipal Contracts

"The original contract for Municipal physicians (1947) was reviewed and compared to the salaries of Civil Service physicians then and now.

"All members of the Committee present felt that there should not be too much emphasis placed on comparison of salaries because of the marked responsibility to the residents of the municipality which must be assumed by the physician as compared to other employees of the Department.

"It must not be forgotten also that the physician is expected to be available at all times every day in the week.

"It was noted that the Chairman of the Legislative and Contract Committee had drawn up a suggested schedule using approximately the same differential as existed in 1947. This schedule is slightly higher than the one finally presented by the whole committee to the Advisory Commission.

"The Manitoba Medical Association Committee on Economics was decidedly in favour of this original proposal for the reasons pointed out above.

"The schedule favoured by the Committee on Economics is as follows:

38.

Municipal Physicians 1954

During 1st year after graduation.....	\$5,256.00
During 2nd year after graduation.....	5,700.00
With Certification for Tonsils & Adenoids.....	6,150.00
After 2nd year with Postgraduate Cert.....	6,150.00
with \$500.00 yearly increments to.....	8,150.00"

Extended Federal Health Grants commenced in May, 1953. Very little action to date.

(a) Maternal and Child Welfare grant has barely been touched.

(b) Rehabilitation. A co-ordinator, Mr. W. N. Boyd, has recently been named and he is now in the process of gathering together a representative committee to act in an advisory capacity.

(c) X-Ray and Laboratory Facilities Grant. The following is an excerpt from a letter to Dr. Morley Young:

"This is a matching grant. The Federal Health Department portion, of course, will pay outright for equipment and training of personnel. This new grant, as far as Manitoba is concerned, simply extends the facilities that we have already built up following the passage of the Manitoba Health Act in 1945. We now have three full time health units, which means three areas where there is a full time health officer who does no practice. In these health units the Provincial and Federal Governments combined, plus the Municipality, have placed x-ray and laboratory equipment. This equipment, or rather these facilities, are at the disposal of the local doctors who are practicing in that area. All the local practitioner needs to do is to send his patient to the hospital or health unit building in which the equipment is housed with orders as to what he wants done and these will be carried out and a report sent back to the physician. There are several other smaller areas in the Province where x-ray equipment only is installed, in such buildings as rural hospitals, Government-owned buildings, etc., and this equipment is used in the same way, to the advantage of the doctor concerned. As far as I can gather, there will be no new developments in this field but a few more x-ray and laboratory facility areas may be developed as time goes on. We in Manitoba feel that this is not getting out of hand. The Association in one way or another has full knowledge of what is going on and feel that we are being consulted and asked for advice whenever it is needed."

39.

Medical Care to Dependents of Service Personnel

The representative of the Brandon and District Medical Association outlined the policy of the Department of National Defence which, since January 1st, has been providing medical and hospital care, including x-rays, drugs, etc., to dependents of service personnel for the sum of \$8.55 daily. Information was referred to the Chairman, Committee on Economics of the Canadian Medical Association. The importance of the problem was realized but it was concluded that in certain areas where civilian medical service is non-existent, inadequate or unavailable, the profession should not object to assumption of responsibility by another body.

Respectfully submitted.

D. L. Scott,
Chairman.

Legislative Committee

To the President and Executive of
The Manitoba Medical Association:

40.

The Legislative Committee of Fifteen had no occasion to meet during the past year.

Respectfully submitted.

F. A. L. Mathewson,
Chairman.

Medical Education

To the President and Executive of
The Manitoba Medical Association:

41.

The Committee on Medical Education met to discuss the educational facilities for the practising physician in Manitoba. The existing educational programmes might be enumerated as follows:

(a) The scientific programme at the Annual Meeting of the M.M.A.

(b) The annual refresher course held under the auspices of the Committee on Post Graduate Studies of the Faculty of Medicine of the University of Manitoba.

(c) The meetings of the Winnipeg Medical Society and the District Medical Societies.

(d) The ward rounds and clinical luncheons at the various hospitals in Winnipeg.

(e) The annual series of weekly lectures arranged by the General Practitioners' Association.

(f) The meetings of various specialized groups, such as the Medical Historical Society, the Medico-Legal Society and various sectional meetings.

The Committee felt that these meetings were excellent and should be carried on in their present form and that notices of these meetings should be carried in the Manitoba Medical Review.

However, the Committee felt that further consideration should be given to a proposal to enhance educational opportunities for the rural practitioner in hopes of helping him to overcome the difficulties of time and space. The proposal was that a team of specialists, a "travelling circus," be sent out to selected points to conduct a one day course under the auspices of the District Medical Societies. It is hoped that the co-operation of the local physicians could be obtained to have this almost entirely as bed-side clinics. Such a proposal has been submitted to the Executive.

Respectfully submitted.

J. P. Gemmell,
Chairman.

Committee on Pharmacy

To the President and Executive of
The Manitoba Medical Association:

42.

No special requests or matters requiring action have been referred to this committee during the past year. Accordingly, no meetings have been held.

Respectfully submitted.

M. J. Ormerod,
Chairman.

Public Health

To the President and Executive of
The Manitoba Medical Association:

43.

As there were no meetings of the Public Health Committee during the year there is nothing to report.

Respectfully submitted.

R. G. Cadham,
Chairman.

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Vitamin B ₁	1 mg.
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Sodium iodide	0.2 mg. (1/325 gr.)

*Average content: calcium 110 mg., phosphorus 50 mg., fluorine 0.4 mg., and other trace elements.

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MONTREAL CANADA

Maternal Welfare

To the President and Executive of
The Manitoba Medical Association:

43A.

The Committee wishes to submit the following report for the year 1953, based upon information supplied by the Division of Statistics, Department of Health and Public Welfare.

The maternal death rate per 1,000 live births was 0.7, there being 15 maternal deaths in 21,469 live births. This compares with previous years as follows:

Maternal Mortality Rates Per 1,000 Live Births Manitoba, 1949 - 1953				
1949	1950	1951	1952	1953
1.3	0.98	1.1	0.5	0.7

The causes of death were as follows:

Toxemias of Pregnancy	6
Eclampsia (postpartum)	2
Pre-eclampsia with placenta abruptio	2
Pre-eclampsia	2
Haemorrhage	5
Intra-abdominal (ectopic)	2
Postpartum hemorrhage	3
Infection	3
Septic abortion (induced)	2
Puerperal sepsis	1
Air embolism	1
Abortion (induced)	1
Total	15

Review of these statistics, and of the maternal mortality reports submitted, reveals the continued prominent role toxemias of pregnancy play as a cause of maternal deaths, again emphasizing the need for adequate prenatal care. Of the 6 patients whose death was attributed to toxemia, only two received adequate care, 2 patients having attended a physician only once during the pregnancy, while the remaining 2 patients had received no care prior to hospital admission.

The committee wishes to commend attending physicians for obtaining a greater number of postmortem examinations, 10 autopsies in 15 deaths as compared to 10 autopsies in 22 deaths as reported by the committee for 1951. It regrets, however, that the maternal mortality reports forwarded by the Department of Health and Public Welfare are only poorly completed.

It was felt to be of general interest to add the deaths associated with pregnancy, tabulated as associate maternal deaths, in 1953. These are as follows:

Cardiac Disease	2
Anterior Poliomyelitis	6

The latter figure emphasizes the danger of anterior poliomyelitis to the pregnant woman.

Respectfully submitted.

Otto Schmidt,
Chairman.

Industrial Medicine

To the President and Executive of
The Manitoba Medical Association:

43B.

A meeting of the Committee was held on August 24, 1954. Several subjects were discussed and as a result the following recommendations were made:

1) That the medical profession become more interested in the working environment of employees who are under treatment for chronic medical conditions. Patients with diabetes, rheumatic heart or coronary disease, epilepsy, asthma, etc., present a definite problem in regard to their employability in certain jobs. The physician in charge should be able to give definite recommendation as to such workers ability to undertake gainful employment and to do this he should have some knowledge of the likely working conditions of any job.

2) That in view of the fact that the life span is being continuously increased (up 4 yrs. in the past decade to an average of 68.5 yrs.) the employment of older workers is

becoming a greater problem each year. The medical profession, in conjunction with management, labor unions, social and employment agencies, should work towards solving some of the many difficulties in providing the older worker with a job and keeping him fit enough to do it.

Respectfully submitted.

Ian Maclean,
Chairman.

Public Relations

To the President and Executive of
The Manitoba Medical Association:

44.

The convention of your Association was well covered by the newspapers and the Canadian Press.

There have been no problems in Public Relations during the past year.

In January, 1954, a series of thirty-nine radio broadcasts on medical topics was begun for presentation each Sunday. These were sponsored financially by the Manitoba Medical Service and the Manitoba Medical Association. It was hoped that they would be used by the Manitoba Medical Service to advertise the prepaid medical plan of the Province, but the latter decided not to use the broadcasts, and it appeared as though the Manitoba Medical Association was the sole sponsor. This was a source of disappointment to the Committee.

Respectfully submitted.

L. A. Sigurdson,
Chairman.

Editorial Committee to C.M.A. Journal

To the President and Executive of
The Manitoba Medical Association:

45.

Your committee begs to report as follows:

During the past year the following doctors have contributed to the C.M.A. Journal: E. F. E. Black, Angus Boyd, C. Corrigan, M. Matas, H. S. Evans, G. B. Elliott, C. C. Ferguson, M. H. Ferguson, J. K. Martin, P. Barsky, M. K. Kiernan, D. L. Kippen, K. R. Trueman, F. A. L. Mathewson, S. Vaisrub, J. W. Simpson, G. C. Sisler, H. G. Hurst, D. W. Penner, A. A. Klass and A. Gibson. Their contributions have been of a high order.

The C.M.A. Journal is the medium for presenting current medical thinking in Canada, and its columns give access to world medical literature. The editor, Dr. H. E. Macdermot, welcomes particularly articles relating developments in original research and reports of rare and unusual cases. It is hoped that Manitoba authors will continue to contribute to our national journal.

Manitoba news notes and abstracts were also contributed regularly.

Respectfully submitted.

Ross Mitchell,
Chairman.

Extra Mural

To the President and Executive of
The Manitoba Medical Association:

46.

The following is an outline of the meetings held during the past year:

Brandon and District Medical Association:

November 4th, 1953, at Flying Club, Brandon:

Dr. J. S. Brown—"Dysphagia."

Dr. J. A. Hildes—"Some Complications in the Treatment of Poliomyelitis."

February 24th, 1954, Prince Edward Hotel, Brandon

(combined meeting with Northern and Northwestern Medical Societies):

Dr. V. J. H. Sharpe—"Addison's Disease."

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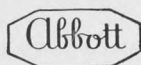
nicotinamide..... 30 mg.

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not a soft capsule*

Dr. W. Forster—"Schizophrenia in Childhood."

Dr. W. P. Hirsch—"Uterine Inertia."

June 9th, 1954, Prince Edward Hotel, Brandon:

Dr. L. R. Rabson—"Surgery in the Aged."

Dr. A. E. Thomson—"Use of Drugs in Hypertension."

Central District Medical Society:

December 14th, 1953, at Mayfair Hotel, Portage la Prairie:

Dr. J. K. Martin—"Diarrhoea in Children."

Dr. C. W. Clark—"Postoperative Parenteral Fluid Balance."

North of 53 District Medical Society:

February 10th, 11th, 1954, at Flin Flon:

Dr. L. G. Bell—"Modern Trends in Medical Education."

Dr. D. Parkinson—"The Treatment of Acute Head Injuries."

Northern District Medical Society:

November 5th, 1953, at Dauphin:

Dr. J. A. Hildes—"Some Complications in the Treatment of Poliomyelitis."

May 20th, 1954, at Dauphin:

Dr. A. T. Gowron—"Varicose Veins."

Dr. J. E. Morris—"Medical Aspects of Thyroid Disease."

Northwestern District Medical Society:

June 24th, 1954, at Virden:

Dr. W. A. McAlpine—"Thoracic Surgery."

Dr. J. R. Taylor—"Management of Urinary Tract Infections."

September 23rd, 1954, at Hamiota:

Dr. Donald Huggins—"Advances in Anaesthesia."

Dr. J. C. MacMaster—"M.M.S.—Insurance for Medical Members."

Southern District Medical Society:

November 19th, 1953, at Carman:

Dr. A. Hollenberg—"Newer Aspects of Diabetes Mellitus."

Dr. R. O. Burrell—"Thrombo-embolic Phenomena."

The commendable efforts of the Societies have resulted in useful and stimulating meetings. However, it is possible that these might be improved and in this respect attention is drawn to the recommendations of the Committee on Medical Education.

Respectfully submitted.

R. E. Beamish, M.D.,
Chairman.

Fee

To the President and Executive of

The Manitoba Medical Association:

47.

Revision of Manitoba Medical Association Fee Schedule:

Following the last Annual Meeting representations were received from members and groups, considered by the Fee Committee, and printing of the Minimum Fee Schedule for Medical Practice was authorized by the Executive Committee. Manitoba Medical Service generously waived some copyright entitlement and the new schedule is to be copyright. Each member of the Association received a copy of the schedule, as did each provincial division of the Canadian Medical Association. Various comments and inquiries have been received.

Manitoba Medical Service:

Several meetings of the Committee were held to consider requests for fees applicable to Manitoba Medical Service and the problems arising since. Such requests were usually for upward revision of fees.

Respectfully submitted.

W. F. Tisdale,
Chairman.

Group Insurance

To the President and Executive of

The Manitoba Medical Association:

48.

This report will fall into two parts.

(1) GROUP, ACCIDENT AND DISABILITY INSURANCE. At the present time 393 doctors are participating in the group, accident and disability, as compared to the 330 doctors originally signed

up. The premiums paid for the year ending September 1st, 1954, have been \$37,338.72. The amount of claims paid out was \$27,299.52, or a loss ratio of 73.11%.

Recently new options have been offered by the company, and this can be discussed in detail when this report is read.

(2) GROUP LIFE — as reported in my letter to the Executive, printed in the Manitoba Medical Review for Aug.-Sept. The proposals made at that time were submitted to the Manitoba Medical Service. Unfortunately that body saw fit to remove the disability clause from the policy offered, and as the policy stands today, a waiver of premium on disability is all it contains in addition to the straight life insurance. Your Committee regrets this decision on the part of the Manitoba Medical Service.

However, at the time of going to press, a 75% enrolment seemed definitely assured. Dr. Michael Hollenberg, who initiated the idea of Group Life Insurance, deserves special commendation on its accomplishment as it appears today.

It is interesting to note that the Group Insurance started in 1949 by the undersigned has spread across the Prairie Provinces and into British Columbia, where the other three medical associations are all participating in both Group Life and Accident Insurance. We in Manitoba may take great pride that the initial steps in this direction were taken by our Association.

Respectfully Submitted.

L. R. Rabson,
Chairman.

Historical Medicine and Necrology

To the President and Executive of

The Manitoba Medical Association:

49.

Dr. Francis Richard Chown, Winnipeg
Dr. John Cruickshank Hossack, Winnipeg
Dr. John McFaul McEachern, Winnipeg
Dr. Peter Nimilowich, Winnipeg
Dr. Isaac Pearlman, Winnipeg
Dr. Earl Dickson Winchell, Brandon

It is with sincere regret that your committee reports the passing of these, our colleagues, during the past year. Each has left his mark, has written his lines upon the pages of medical history, has laid by his instruments and proceeded to his reward.

Such was the nature of their work and such was their philosophy that were they themselves to write these lines, they would of themselves say nothing. We shall not praise them, but rather in full confidence, allow their works to speak. If those works could be assembled, they would form a magnificent monument to their memory, but the invisible monument is by far the best. Those nearest and dearest to them will know that this is true.

Requiescat in pace.

Respectfully submitted.

Athol R. Gordon, M.D.,
Chairman.

Liaison, C. P. & S. - M. M. A.

To the President and Executive of

The Manitoba Medical Association:

50.

This Committee was set up in 1947 to further co-operation among the various organizations in the matter of the combined business office and staff. The salary of the Executive Secretary was reviewed. The Winnipeg Medical Society agreed to a monthly increase for accommodation and secretarial services. The General Practitioners' Association has agreed to assume some responsibility in this respect, the amount to be decided. Notice has been received of an increase in office rental costs. Continuation of the efforts of this joint Committee is recommended.

Respectfully submitted.

W. F. Tisdale,
Chairman.

for rapid treatment and prevention of infantile diarrheas

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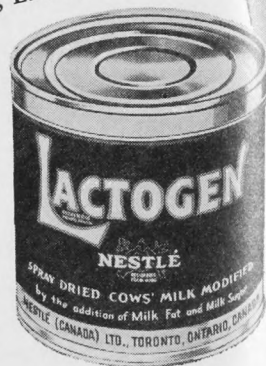
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Manitoba Sanatorium Board

To the President and Executive of
The Manitoba Medical Association:

51. Meetings of the Board have been held as usual and reports received from the various committees.

The medical advisory board have nothing of interest to report.

It might be of interest to the members to know that the King Edward Hospital has closed its doors to tuberculous patients, as there have been empty beds at the other sanatoria which need to be filled, thus relieving the city of a financial burden.

Respectfully submitted.

M. B. Perrin,
Representative.

Pensions

To the President and Executive of
The Manitoba Medical Association:

52. The Committee has had several meetings, and on the 23rd of September, 1953, I proposed to the Manitoba Medical Service that, whereas medical men are self-employed and therefore do not enjoy the privileges of tax-exempt pension funds, provision be made to equalize the earning and life-expectancy curves. Income tax would be payable, not at the time of earning, but at the time of receiving the income. Deductions from monthly income cheques would be made for this purpose. Money owing to the doctor could be called at his request.

This proposition was submitted to our lawyer, Mr. D. A. Thompson, Q.C., who, in his report, concludes that if the proposals meet with the general approval of the M.M.A. and the M.M.S., they should be considered with a view to setting up a detailed plan involving in the first instance 5% of the annual charges. If this were favorable, and no reaction ensued, this could be increased as desired. Eighteen months to two years of plan operation would be sufficient to ascertain the workability of this plan.

Respectfully submitted.

M. S. Hollenberg,
Chairman.

Post-Graduate Committee

To the President and Executive of
The Manitoba Medical Association:

53. The Chairman of this Committee was Dr. D. S. McEwen and the Secretary-Treasurer Dr. J. P. Gemmell.

Sixty-five doctors attended the Refresher Course which was held in Winnipeg from April 12 to April 15, 1954. The Guest Speakers were Dr. F. S. Brien, Professor of Medicine, University of Western Ontario, London, Ontario, and Dr. W. H. ReMine, Division of Surgery, Mayo Clinic, Rochester, Minnesota. The various sessions were held at Deer Lodge Hospital, Princess Elizabeth Hospital, Children's Hospital, St. Boniface Hospital and the Winnipeg General Hospital. Numerous local speakers also contributed toward the success of this course.

Respectfully submitted.

Arthur E. Childe, M.D.,
Representative.

Workmen's Compensation Board Medical Referee Committee

To the President and Executive of
The Manitoba Medical Association:

54. During the previous twelve month period your committee met on eighteen occasions and considered forty-nine patients, three of whom were from the Province of Saskatchewan. No undue difficulties were encountered.

Respectfully submitted.

C. E. Corrigan,
Chairman.

Workmen's Compensation Board Negotiating Committee

To the President and Executive of
The Manitoba Medical Association:

55.

The Negotiating Committee of the Manitoba Medical Association to the Workmen's Compensation Board did not hold any meetings during the past term, due to the fact that there were no complaints from any of the members of the M.M.A. nor from Commissioner G. L. Cousley, Q.C., of the Workmen's Compensation Board.

Respectfully submitted.

P. H. McNulty,
Chairman.

General Practitioners' Association of Manitoba

To the President and Executive of
The Manitoba Medical Association:

56.

The General Practitioners' Association of Manitoba had a busy year. The major accomplishment was helping in the formation of the College of General Practice of Canada. This organization hopes to improve the general status of the General Practitioner by encouraging up-to-date Post Graduate studies and improving the position of the General Practitioner in the Hospital, eventually aiming for a chair of General Practice in the Hospitals with active staff privileges.

A Refresher Course in Internal Medicine was sponsored by our groups and the attendance was increased over previous years.

A successful Valentine Dance in February was crowded with doctors and their wives enjoying a carefree evening.

On our instigation the Manitoba Medical Association was pleased to form a Hospital Committee to investigate and recommend changes in Hospital and Doctor relationship. Any General Practitioner who has a grievance may submit this in writing to the General Practitioner Executive who will forward it to the Hospital Committee of the Manitoba Medical Association.

At the Annual Meeting of the Manitoba Medical Association a dinner and get-together is planned for October 12, 1954.

Respectfully submitted.

Donald J. Hastings,
Recording Secretary.

Surgical Section

To the President and Executive of
The Manitoba Medical Association:

57.

The Surgical Section of the Manitoba Medical Association held three dinner meetings during the year, one in November, one in February, and one in May.

Dr. Donald Penner gave a very interesting and provocative paper on "How Good is Our Surgery?"

Dr. Colin Ferguson, Professor of Surgery, spoke on "The Future of Surgical Education in Manitoba." A very lengthy and interesting discussion followed this paper.

The final meeting of the year was held at the Manitoba Club, where Dr. Gordon Murray, of Toronto, spoke on "Blood Vessel Surgery." This paper was accompanied by films and colored slides, and proved to be a most interesting dissertation.

All these meetings have been attended by at least thirty or more surgeons and have proved to be most profitable to all. Dr. M. R. MacCharles has occupied the chair at all these meetings.

The next meeting will be on the 21st October when Dr. Heim de Balsac, of Paris, France, will speak on "Surgery of Acquired Heart Disease."

Respectfully Submitted.

L. R. Rabson,
Secretary.

in the COMMON COLD

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others
fail...*



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In a study of 5,734 patients with the common cold treated with CORICIDIN "... relief of symptoms was 72.7 per cent"*. Side effects were mild and their incidence was only 1.5 per cent greater than with the placebo.

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* Manson, M. H.; Wells, R. L.; Whitney, L. H.; and Babcock, G., Jr.:
Internat. Arch. Allergy & Applied Immunol 1: 265, 1951.



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CORPORATION LIMITED, Montreal

Editorial

To the President and Executive of
The Manitoba Medical Association:

58.

During the past year, we have endeavoured under many difficulties to make every issue of the Review, a local post-graduate course and a voice aimed to represent the views of the Executive, as well as the intimate problems of the medical profession in this province.

Since there was no annual meeting in 1953, the usual number of papers for a back-log were non-existent. Not one paper was received from the 1954 Refresher Course. Many of the Sections which contributed papers in the past failed to do so this year.

The lack of material available for publication at the deadline of each month, creates untold anxiety and humiliation to our business manager, Mr. Whitley. No one realizes how much time and effort he devotes to the Review and how proud he is when the issue is a success. We owe him a great deal, mostly in the way of co-operation. Surely, this is not too much to ask. We feel that the Review is the responsibility of the entire profession.

We feel deeply the loss of our late editor, Dr. J. C. Hossack, who contributed so much, for so many years, to raise the Review to its present high standard. He will be sorely missed.

Important issues pertaining to the future of the Review and matters of general policy were discussed in detail at your Executive Meeting. We wish to thank the President, Dr. W. F. Tisdale and his committee for the sincere and sympathetic audience accorded us.

Should the recommendations of the Editorial Committee bear fruit (see November Review for report), we have every confidence that the format for future Reviews will improve and our periodical will become richer in educational value.

Dr. M. T. Macfarland has kept the readers well informed on all business aspects and Dr. Borthwick-Leslie still maintains her inherent knack of digging up social gossip.

Beginning with the January 1954 issue, Mr. Whitley has dressed the Review in a new cover design which met, not only with approval, but also with praise from near and far.

Our sincere appreciation is extended to the Executive for their expressed interest; to all those who so helpfully contributed material; to the advertisers for their continued support and to our printer for his patient co-operation.

Respectfully Submitted.

S. S. Peikoff,
Chairman.

Opium and Narcotic Drug Act Regulations

"One of the main items in the new Regulations is the definition of an 'oral prescription narcotic product.' In brief, it is medication containing a narcotic drug in combination with two or more non-narcotic medicinal substances in recognized therapeutic dose and not in a form intended for parenteral administration. This is the type of medication a pharmacist may dispense on the strength of an oral prescription issued by a physician, dentist or veterinary surgeon, providing, of course, certain precedures are followed. Sales of all straight drugs as well as narcotic preparations not coming within this category may only be sold by a pharmacist upon receiving a signed and dated prescription. Moreover, prescriptions calling for any narcotic medication, whether written or orally given, cannot be repeated by a pharmacist."

new
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curbs eye inflammation

combats eye infections

protects injured eyes

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Cortomyd can be used for its anti-inflammatory and anti-bacterial effects without interference with normal use of the eye. Symptomatic relief is obtained often in minutes, infection controlled frequently within hours.

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1.5% (15 mg. per cc.) **cortisone** acetate (CORTOGEN ACETATE) with 10% (100 mg. per cc.) sodium **sulfacetamide** (SODIUM SULAMYD).

Packaging:

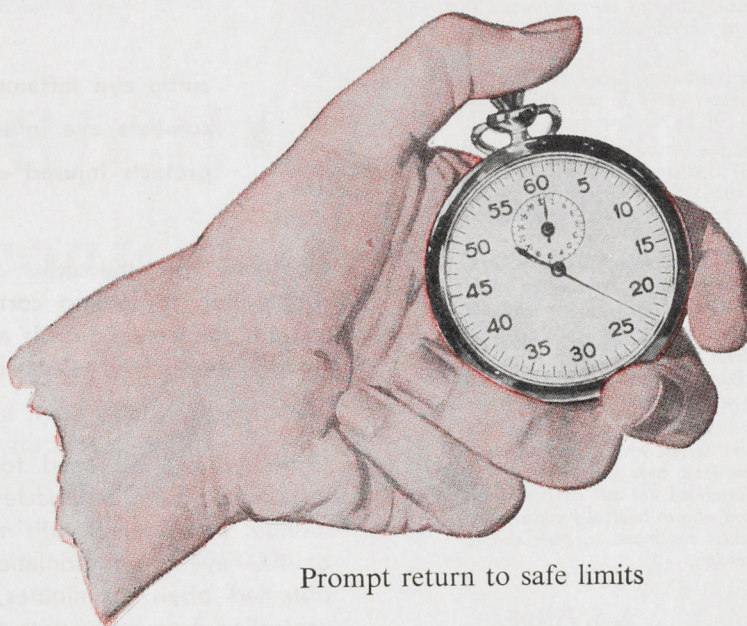
5 cc. dropper bottle, Ophthalmic Suspension
Sterile; 1/8th ounce tube Ophthalmic Ointment.

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Literature on request

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College of Physicians and Surgeons of Manitoba

Executive Committee

Winnipeg, Manitoba,
March 4th, 1954.

A meeting of the Executive Committee was held in the Medical Arts Club Rooms at 8 p.m., on Thursday, March 4th, 1954.

Present—Dr. C. B. Stewart, Chairman, Dr. A. R. Birt, Dr. Ed. Johnson, Dr. G. H. Hamlin, Dr. C. H. A. Walton, Dr. T. W. Shaw, President, ex-officio, and Dr. M. T. Macfarland, Registrar, ex-officio.

1. Business Arising from Minutes of Council Meeting Held October 17, 1953.

A. Amending of By-laws

The Registrar reported on the progress he and the College solicitor had made in consolidating the By-laws. He advised he expected to have the final copy mimeographed and circulated to the members of Council before the May meeting.

B. Personal Interview Required for Each Foreign Applicant

A resolution was passed at the October meeting of Council that a personal interview be required from each foreign applicant. It was reported that some difficulty had occurred with physicians who had secured their Enabling Certificates elsewhere, and were applying to Manitoba for registration in order to obtain reciprocal registration with the General Medical Council. It was agreed that the Registration Committee should deal with this matter and bring it before Council if necessary.

C. Printing of Application Forms

The Registrar reported that the Registration Committee had gone over the application form in rough draft, and it was now being prepared for the printer. In order to have the College seal included on the application forms, it has been necessary to have a drawing made of the seal, and a cut prepared.

D. Discipline Committee—Re: Dr.

The Chairman of the Discipline Committee advised that at the October meeting of Council he had reported on correspondence which the College had concerning Dr., and the Discipline Committee had been directed to interview him. The Chairman presented the following report which was addressed to the Chairman of the Executive Committee.

"Pursuant to our report to the Council at the annual meeting on October 17th, Doctor, on request, met with Doctor A. P. Guttman, Doctor Macfarland and myself on November 26th. At this meeting the complaints made by Mrs. were fully investigated.

From our interview with Dr. and from the information obtained from other sources and contained in the file, we were unable to elicit any conclusive evidence of negligence or poor judgment on the part of Doctor in handling this case.

Doctor was advised of our findings and was told that this finding would be communicated to the Executive Committee of the Council with a recommendation that the complainant, Mrs. be advised of this finding."

Motion: "THAT the report of the Discipline Committee be adopted." Carried.

Motion: "THAT Mrs. be advised through the Registrar of the findings of the Discipline Committee." Carried.

E. Medical Council of Canada—Internship

Dr. C. H. A. Walton advised that at the September meeting of the Medical Council of Canada a regulation, which was subsequently approved by the Governor General in Council, was passed that the Licentiate would not be granted unless the candidate had served one year's internship in a hospital approved by the provincial licensing body. All provinces but one agreed with the regulation. Although the regulation was passed, Ontario felt so keenly that they have threatened suit, and the feeling is that if the matter went to the Courts, it might be disastrous to the Medical Council of Canada. The L.M.C.C. is the only method of being licensed in Ontario, and it is many years since they have registered anyone without an L.M.C.C., so this regulation would make a hardship in that Province. The University of Toronto and the University of Western Ontario give the degree at the end of the fourth year and do not require an internship. The regulation stood at the September meeting of the Medical Council of Canada, but since that time information has been received and the Executive have temporarily suspended the regulation because it does not want court action. The Registrar read a communication from Dr. Cluny Macpherson, Registrar of the Newfoundland Medical Board, who is 1st Vice-President of the Medical Council of Canada, suggesting that the matter be discussed at the Registrars meeting in Vancouver in June, and again when the Medical Council of Canada meets in September. No action was taken.

2. New Business.

A. Complaint From Drug Store Re Coded Prescriptions

The Registrar presented correspondence which he had with a Drug Store, in which Mr. stated he had been given a prescription from the Clinic which was in code, and inquired whether the College could take action to have

doctors write prescriptions so that they may be deciphered by any or all pharmacists. The Committee agreed no further action could be taken, other than the Registrar's interview with Mr. _____.

B. Request for Donation for Magazines for Medical Arts Club

The Registrar presented a communication from the Medical Arts Building Limited advising that the subscriptions to magazines had expired and inquiring whether it was the intention of the College to renew the contribution to the Medical Arts Club. The letter also advised that the club would provide suitable hard covers for the magazines, in order to assure Club members that the magazines would be kept in good readable condition.

In May, 1952, the College donated the sum of Fifteen Dollars (\$15.00) towards the purchase of periodicals for the Medical Arts Club.

Motion: "THAT the College of Physicians and Surgeons of Manitoba donate the sum of Fifteen Dollars (\$15.00) to the Medical Arts Club for the renewal of the magazine subscriptions." Carried.

C. Re: Dr. _____

The Registrar outlined the correspondence and interviews he had with Dr. _____, and advised that his name had been placed on the Confidential Restricted List by the Narcotic Division of the Department of National Health and Welfare. Dr. _____ has moved to British Columbia, and the Registrar inquired what the policy of the College should be in cases of this nature.

The Registrar advised that before a physician is placed on the Restricted List there is usually an agreement between the Department and the person concerned, but if the agreement is broken he is put on the list. Evidence of good faith on his part after a lapse of time is required before he is removed from the list. The Registrar advised that usually the College is not advised before a Manitoba physician is put on the Restricted List, and in the case of Dr. _____, information was received in the office which led to an inquiry being addressed to the Narcotic Division.

The Committee agreed that it was difficult to lay down any definite action in these matters, since it would depend on the circumstances of each individual case.

D. Correspondence Between M.M.A. & M.M.S. Re Use of the M.M.S. Board Room for Meetings

The Registrar presented a copy of letter addressed to the Manitoba Medical Association from the Manitoba Medical Service advising that the following resolution was passed at their Board of Trustees meeting held November 23rd, 1953: "that the use of the M.M.S. Board Room be offered to the two provincial organizations—College of Physicians & Surgeons and Executive

Committee of Manitoba Medical Association—for their plenary meetings, on the understanding that priority is reserved for M.M.S. meetings and that timely notice be given to the M.M.S. Administrator by the Chairman of each organization."

The Committee agreed that the use of the M.M.S. Board Room was restricted to Council Meetings and M.M.A. Executive Meetings rather than smaller groups, and the Registrar was requested to explore the possibility of the Registration Committee using it for personal interviews of foreign applicants since it would be advantageous to the Committee.

E. Payment of Gratuity to Registrar

Motion: "THAT the payment in December, 1953, of One Hundred Dollars (\$100.00) gratuity to the Registrar be confirmed." Carried.

F. Inquiry From Winnipeg General Hospital Re Use of a Coroner's Inquest Following Untoward Hospital Deaths

The Registrar presented a communication from the Acting Secretary, Honorary Attending Staff, Winnipeg General Hospital, inquiring as to what changes have been made recently through the office of the Attorney General affecting the use of a coroner's inquest following untoward hospital deaths. The matter is of importance to the profession generally and may affect all types of treatment and it will certainly influence patients as well as the profession and the result may be more harmful than beneficial. Specifically the inquiry was based upon the recent calling of a coroner's inquest following the death of a patient in the hospital, in whose treatment electric shock therapy was employed.

The Chairman also outlined a conversation he had with the Provincial Coroner when he was informed that the Superintendent of the Psychopathic Hospital had received a directive from the Department of the Attorney General that an inquest should be held on all cases in which death followed. The case under discussion was that of a patient from Saskatchewan who, while being treated for shock therapy under anaesthesia, succumbed and an inquest was ordered by the Attorney General. The Provincial Psychiatrist advised the Registrar he had received a letter from the Minister of Health that a public inquiry be held in all cases of Provincial Institution deaths, to which a reply was sent that it would be better to limit to cases of violence or accident. It was still being discussed when the Saskatchewan patient died in the General Hospital and an inquiry was ordered.

During the discussion it was pointed out that deaths resulting from shock therapy are very unusual, the last one occurred in 1940 and since then there have been over 12,000 treatments, and if the ruling by the Attorney General's Department concerns shock treatment only there is nothing too

much to worry about since it would be good protection for the medical profession to have an inquest in such deaths.

Motion: "THAT the Registrar be instructed to have an informal conversation with the Deputy Attorney General to obtain information as to the stand of the Attorney General with regard to inquests of deaths in hospitals, and that the Honorary Attending Staff of the Winnipeg General Hospital be advised that the matter is under study at the present time." Carried.

G. Complaint Re Dr.

Letter From Mr.

The Chairman of the Taxing Committee stated that this was a case of Unsatisfied Judgment. Dr. cared for two children who had been in a car accident, and called in a consultant for head injuries. The matter went to court, and Dr. submitted a bill — \$1,150.00 — \$650.00 for the boy and \$500.00 for the girl. The consultant who saw them submitted a bill for \$60.00. The Judge is concerned about the size of the account submitted by Dr. and has asked Mr. to get a ruling from this College.

The Committee agreed that the matter should be referred to the Taxing Committee, and that Dr. prepare an itemized statement of his charges and appear before the Committee.

Motion: "THAT the account submitted by Dr. be referred to the Taxing Committee for consideration." Carried.

The Committee agreed that instead of deferring this matter to the May Council meeting, that the report of the Taxing Committee be circulated to the members of the Executive Committee for ratification.

H. Waiving of Annual Fees—Dr.

Dr. registered in 1917, served in the Medical Corps 1917-19, in China 1919-43, and has reached the age required for Life Membership.

Motion: "THAT the payment of future annual fees by Dr. be waived." Carried.

I. Acknowledgment of Life Membership

From Dr.

The Registrar presented a communication from Dr. acknowledging his Life Membership Certificate and requesting his grateful appreciation for the recognition accorded him be conveyed to the President and members of Council.

J. Correspondence With C.P. & S.,

Saskatchewan, Re

The Registrar presented a communication from the College solicitor outlining an action for libel brought against the College of Physicians and Surgeons of Saskatchewan. He also presented the Text of Judgment published in the Saskatoon Star-Phoenix. This was for information only.

K. Communication From Department of National Defence Re Redistribution of Health Manpower

Resources Across the Nation, in the Event of a National Emergency

The Registrar read the following communication received from the Defence Medical and Dental Services, Advisory Board:

"At the last meeting of this Board, consideration was given to various planning problems involving a possible need for the redistribution of health manpower resources across the nation, in the event of a national emergency. It became obvious that some clearly defined two-way channel of liaison, consultation and advice between this Board and the conjoint interests of the statutory provincial registration authorities (medical, dental and nursing) would be highly desirable, for the final development of emergency planning as well as for the effective operation of such planning should the necessity arise.

"Study is now being given to the possibility of a modest expansion in the composition of the Board to provide representation of certain national professional interests not now included on the Board's membership. It is evident that it would be beyond the bounds of practicability to seek representation from each of the provincial authorities governing the registration of the medical, dental and nursing professions.

"Under these circumstances, I am directed by the Board to invite the advice of the Registrars of all the statutory provincial medical authorities regarding a way whereby their conjoint interests might best be represented in performance of the functions and duties of this Board. For your convenience in this connection, a copy of the Order-in-Council now governing the Board is attached (P.C. 4291 of 24 August, 1949).

"The Board has been informed that in the past it has been customary for the Provincial Registrars to meet informally at the annual meeting of the Canadian Medical Association, I am to invite an expression of your views whether consideration of this problem might appropriately be contemplated at the next such conference, and whether it might be possible that Registrars be vested with authority on behalf of their respective Councils to reach a mutually agreeable decision in this regard, at such meeting."

It was agreed that this matter be discussed at the meeting of the Registrars in June and the results of the discussion be reported to Executive and/or Council.

L. Re Meeting of Registrars at Vancouver in June, 1954

Motion: "THAT the Registrar be authorized to attend the meeting of the Registrars in Vancouver in June, to be held in conjunction with the Annual Meeting of the Canadian Medical Association, the expenses to be paid by the College of Physicians and Surgeons of Manitoba." Carried.

M. Gordon Bell Memorial Fellowship

The Registrar presented a communication from Dr. _____, Professor of Surgery, University of Manitoba, in support of Dr. _____ application to receive the Gordon Bell Memorial Fellowship, together with communications from Dr. _____. Dr. _____ four-year graduate training have been spent largely in residences in surgery at the Winnipeg General Hospital with one year as a Teaching Fellow in Anatomy at the University of Manitoba Medical College. His present position is Resident in Surgery and Surgical Teaching Fellow at the Winnipeg General Hospital, and he has an appointment as assistant resident for one year beginning July 1, 1954, at the Memorial Hospital for Cancer and Allied Diseases, New York.

Motion: "THAT these communications be referred to the Trustees of the Gordon Bell Memorial Fund, and that this Committee accepts the decision of the Trustees, which, if favourable, be reported to Dr. _____." Carried.

N. Purchase of Bonds

The Registrar advised that on instructions from Council, \$6,000.00 of Province of Manitoba 4¼% debentures due October 1st, 1968, had been purchased.

O. Canadian Medical Directory

The Registrar presented a communication from Dr. _____ advising that the suggestion had been made that a Canadian Medical Directory, similar to the one published in the United Kingdom, be published containing the names, addresses, qualifications and publications of all doctors licensed to practise. Much of the required information is already available through Modern Medicine of Canada, and it is intended to supplement this information from a questionnaire to be sent to doctors which will make the entries briefly biographical. It is proposed to publish the first copy in August or September, 1954, which will be followed by publication of correction lists. The co-operation of this College was requested by exchanging lists of additions and changes which would be beneficial to both organizations.

An Editorial Advisory Committee will be formed, representative of Canadian Medicine, and suggestions for persons to represent the register on the Editorial Advisory Committee were requested. This will also have representatives from the Colleges and from Organized Medicine, the Canadian Medical Association and Union Medicale.

The Committee agreed that this College should not send representatives to the Editorial Advisory Committee of the Canadian Medical Directory since it is a commercial organization.

The Registrar also presented a communication from the Deputy Minister of National Health advising that a re-survey of the physicians in Canada will be carried out in order to keep the Physicians Register up-to-date. He advised that

this College has been forwarding to the Department a copy of the list of physicians in Manitoba twice yearly, plus the periodic lists of additions and changes.

P. Request for Change of Name

The Registrar advised that _____ wished to have her name changed on the records of the College to her married name _____. Her Certificate of Marriage under date of January 1, 1954, was presented.

Motion: "THAT the name of _____ be changed to _____ on the records of the College of Physicians and Surgeons of Manitoba." Carried.

Q. Appointment of _____ as Commissioner for Oaths

The Registrar advised that as requested by the Registration Committee, _____ had been appointed as Commissioner for Oaths for the Province of Manitoba, which will be in effect for two years from the 16th of February, 1954.

Motion: "THAT the certificate of Commissioner for Oaths be suitably framed." Carried.

R. Communication From Grace Hospital

The Registrar presented a communication from the President of the Medical Staff of Grace Hospital, requesting the approval of Grace Hospital internships for D.P. doctors who wish to write the Dominion Council Examinations. It is a General Hospital of 230 beds of which sixty are obstetrical. There were 1,800 deliveries last year.

The hospital was granted provisional accreditation by the Joint Commission on Hospital Accreditation, and expects full accreditation will be given after the next inspection, as many changes have been made. Internes at Grace Hospital are invited to four Teaching Sessions per week at Deer Lodge and Misericordia Hospitals, and during the forthcoming year some of these meetings will be held at Grace Hospital.

The Chairman of the Registration Committee stated that in the past the Committee has accepted Grace Hospital training but has dealt with each problem on its merits, and if a definite answer were given the Committee would have to comply. He suggested that the matter be handed over to a joint committee of the Faculty of Medicine and the College.

Motion: "THAT the College of Physicians and Surgeons of Manitoba inquire, on the basis of the communication from Grace Hospital, whether the Faculty of Medicine of the University of Manitoba would consider the formation of a joint committee to assess hospitals suitable for interne training." Carried.

U. Transferring of Certificates of Licence (Temporary) to Certificates of Registration

The Registrar advised that if Certificates of Licence (Temporary) are transferred to Certificates of Registration during the lifetime of the temporary certificate, the fee is credited to the per-

manent registration fee, and inquired whether this should be done when there is a lapse of time between the cancellation of the temporary certificate and the issuance of permanent registration.

Motion: "THAT if a Certificate of Registration is taken out during the life of the Certificate of Licence (Temporary), the fee be credited to permanent registration, otherwise the whole fee be charged." Carried.

Adjournment

The Semi-annual meeting of Council will be held on Wednesday, May 19th, 1954.

Registration Committee

March 30, 1954

Enabling Certificate Deferred

Wei Yu Kao—M.D., St. John's U., Shanghai, 1945.

Enabling Certificates Granted

Henrich Jackh—M.D., U. Heidelberg, 1947.

Walter Zingg—M.D., U. Zurich, 1951.

Eugenijus Gedgaudas—M.D., U. Munich, 1948.

Chung-kuo Liao—M.D., West China Union U., 1941.

Jazeps Teodors Beldavs—M.D., U. Latvia, 1940.

Certificates of Registration Deferred

Thomas Noel Hurley—L., L.M., R.C.P., Irel., 1950; L., L.M., R.C.S., Irel., 1950.

Roman Buczok—M.D., U. Madrid, 1951.

Robert Alexander Christie—M.B., Ch.B., U. Aberdeen, 1951.

Certificate of Registration Confirmed

Richard Thomas Hastings-James—M.R.C.S., Eng., 1940; L.R.C.P., Lond., 1940; M.B., B.Chir., U. Cambridge, 1940; M.A., U. Cambridge, 1943; M.D., U. Cambridge, 1948; M.R.C.P., Lond., 1948; D.M.R.D., England, 1950.

Certificate of Registration Granted

Charles Mullen McLean—M.B., Ch.B., U. Glasgow, 1939; D.O.M.S., R.C.P.S., Eng., 1950.

Certificate of Licence (Temporary) Renewed

James Stuart Hitsman—M.D., C.M., Queen's U., 1943; L.M.C.C., 1943.

Registration Committee

April 21, 1954

Enabling Certificate Deferred

Woldemar Artes—M.D., Stalin Medical Institute, 1936.

Enabling Certificates Granted

Dieter Kirchheim—M.D., Johann Wolfgang Goethe U., Frankfurt-am-Main, 1951.

Hseuh I Yuan—M.D., Cheeloo U., 1947.

Certificate of Registration Deferred

Ralph Fredman—L.R.C.P., Edin., 1941; L.R.C.S., Edin., 1941; L.R.F.P.S., Glasg., 1941.

Certificate of Licence (Temporary) Confirmed

Ivor Frederick Barwell-Clarke—M.B., B.Ch., U. Wales, 1944; F.R.C.S., Eng., 1949; L.M.C.C., 1953; F.R.C.S. (C), 1953.

Certificates of Licence (Temporary) Granted

Robert Alexander Christie—M.B., Ch.B., U. Aber-

deen, 1951.

Thomas Noel Hurley—L., L.M., R.C.P., Irel., 1950; L., L.M., R.C.S., Irel., 1950.

Michael Ryan—M.B., B.Ch., National U. Ireland, 1951.

Correspondence With Command Medical Officer, Prairie Command, Re Licensing of Medical Officers Stationed in Manitoba

The Registrar outlined the correspondence and conversations he had with the Command Medical Officer concerning the difficulties of licensing medical officers stationed in Manitoba, and the lapse of time which often occurred from the time they arrived in the province until they became licensed, and the difficulty of having the Certificates returned for cancellation when they were posted out of the province.

He presented an order, dated April 9th, 1954, which the Command Medical Officer proposes to issue.

The Registrar stated that the Command Medical Officer feels that the initial fee of \$10.00 for the Certificate of Licence (temporary) should be charged to all medical officers since it is recoverable.

Motion: "THAT the Registration Committee recommend to Council in May that the fee for Certificate of Licence (temporary) granted to Medical Officers be Ten Dollars (\$10.00) when the amount is recoverable by the Officer." Carried.

Registration Committee

April 28, 1954

Personal Interviews

King-Shue Luke — M.D., National Hsiang-Ya Medical College, 1943; L.M.C.C., 1953.

Daisy Corbin (Sih-En Feng)—M.D., National Medical College of Shanghai, 1938.

Edith Shu Ai Hwang—M.D., Cheeloo U., 1938.

Ching Po Yang—M.D., Peiping Union Medical College, 1931.

Min Kun Kwong—M.D., U. Paris, 1930.

James Jee Yan Ch'uai—M.B., Ch.B., Mukden Medical College, 1930.

Certificate of Licence (Temporary) Granted

Anthony Sartorelli—M.D., U. Toronto, 1949; L.M.C.C., 1949.

Council Meeting

Winnipeg, Manitoba,

May 19th, 1954.

A Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Wednesday, May 19th, 1954, at 9 a.m., D.S.T., in the Board Room of the Manitoba Medical Service Building, Winnipeg.

In the temporary absence of the President, Dr. T. W. Shaw, the Vice-President, Dr. C. H. A. Walton took the chair and called the meeting to order.

1. Roll Call.

The following members were present: Doctors: T. W. Shaw, President; C. H. A. Walton, Vice-President; T. H. Williams, Treasurer; A. R. Birt, W. J. Boyd, C. E. Corrigan, B. Dyma, A. P. Guttman, G. H. Hamlin, Ed. Johnson, P. Johnson, Wm. Malyska, F. K. Purdie, F. H. Smith, C. B. Stewart, Wm. Watt, and M. T. Macfarland, Registrar.

2. Reading of the Minutes and Their Approval.

The Chairman advised that mimeographed copies of the minutes of the Annual Meeting of Council held October 17th, 1953, had been forwarded to each member of Council.

Motion: "THAT the minutes of the Annual Meeting of Council held October 17th, 1953, be accepted as having been read." Carried.

Business Arising From Minutes of Council Meeting Held October 17, 1953

A. Appointment of Auditors

Motion: "THAT Price Waterhouse & Co. be appointed auditors for the year 1953-54." Carried.

3. Reports of Officers and Their Consideration.

A. Treasurer's Report

Your Treasurer begs to report as follows:

Investment Trust Account—There are \$60,000 in Dominion of Canada 3% fully registered bonds in the safety deposit box belonging to this account and \$6,000.00 Province of Manitoba 4¼% 1968 fully registered bonds. The market value of all these bonds has increased recently and the majority are above par with the Province of Manitoba bonds at \$105.60. These bonds were purchased at approximately \$101.2 last November. The wisdom of not disposing of our 3% bonds when the market value was down in order to purchase others of higher interest rate is now apparent. There was paid from this account since our last meeting \$750.00 to the Medical Library and \$231.28 for Extra Mural Post Graduate expenses. The balance on hand in the cash account at present is \$1,088.65.

Gordon Bell Memorial Trust Account—No payments have been made for scholarship from this account since our last meeting. There are \$25,500 Dominion of Canada fully registered 3% bonds to the credit of this account. Cash balance on hand is \$993.03.

Current Account—Credit balance on hand in this account is \$6,132.66 as compared with \$7,293.92 a year ago. However, \$4,074.32 from this account was used for purchase of Province of Manitoba bonds since our October meeting, and transferred to Investment Trust account. The favorable condition of this account is due to continued high rate of registration of applicants from abroad. This cannot be depended upon to continue and when it falls off a deficit may be expected.

T. H. Williams, M.D., C.M.

Motion: "THAT the Treasurer's Report be accepted." Carried.

4. Reports of Standing Committees and Their Consideration.

A. Executive Committee

The Chairman advised there had been one meeting on March 4, 1954, of the Executive Committee held since the October Council meeting, and mimeographed copies of the minutes had been distributed to each member of Council.

Motion: "THAT the minutes of the Executive Committee meeting held March 4, 1954, be accepted as having been read." Carried.

Business Arising from Minutes of Executive Committee Meeting Held March 4, 1954

(a) Amending of By-Laws

The Chairman of the Legislative Committee advised that at the Annual Meeting of Council in October, 1953, a Notice of Motion was given "THAT the By-laws, Rules and Regulations of the College of Physicians and Surgeons of Manitoba be consolidated in conformity with the 1953 amendments to the Medical Act, and changes recommended to date by Council." He stated that a draft of the By-laws was drawn up by the solicitor, the Registrar, and himself, and that copies had been mailed to all members of Council. He asked the opinion of Council whether the By-laws should be gone over section by section, or whether Council should resolve itself into a Committee as a Whole to discuss the amended By-laws.

The Council agreed to postpone consideration of the By-laws, Rules and Regulations until item 4E on the agenda, and to go into a committee as a whole at that time.

(b) Printing of Application Forms

The Registrar presented copies of the printed application forms, outline of requirements for Registration, Temporary Licence, and Enabling Certificates, and reference forms.

Motion: "THAT the printed application forms, outline of requirements, and reference forms, for use by the College of Physicians and Surgeons of Manitoba, be approved, with one change, i.e. inserting the word "or" after numbers 1 to 5 under requirements for Certificate of Registration." Carried.

The Chairman read a communication from Professor W. M. Hugill of the Department of Classics, University of Manitoba, addressed to Dr. Ross B. Mitchell, in which he suggests a possible explanation to the College seal. Dr. A. R. Birt suggested that a picture of the seal, and Professor Hugill's suggested explanation, be published in the Review, and it may be possible that someone seeing it would know the original intention of the designer. Council agreed to this.

(c) Dr. _____

The Chairman of the Executive Committee advised that as directed by Council in October, 1953,

the Discipline Committee had interviewed Dr. _____ and their findings had been reported to the meeting of the Executive Committee held March 4, 1954. The Registrar was directed to advise the complainant of the findings of the Discipline Committee, and he stated this had been done.

(d) Medical Council of Canada—Internship

Dr. C. H. A. Walton read the report from the minutes of the Executive Committee meeting held March 4, and said there was no further report to make. He stated that Ontario is trying to work out some method of solving this problem without recourse to the courts. Hospitals in Ontario do not take internes who are not registered and there is a shortage of internship appointments for the number of students taking medicine in the schools in Ontario.

**(e) Inquiry From Winnipeg General Hospital
Re Use of a Coroner's Inquest Following
Untoward Hospital Deaths**

At the meeting of the Executive Committee held March 4th, the Registrar was directed to have informal conversation with the Deputy Attorney-General to obtain information with regard to inquests of deaths in hospitals. The Registrar advised that the Deputy Attorney-General had stated that there are no special regulations or directives concerning coroner's inquests, and that the coroner decides or the hospital requests that such be carried out. He also stated he had a phone call from the Provincial Coroner which prompted him to write a letter of inquiry to the Attorney-General. He read the following letter which he received in reply from the Deputy Attorney-General:

"I acknowledge receipt of your letter of May 10th, addressed to the Honourable Ivan Schultz, Q.C., requesting to be advised if there are any regulations under The Coroners Act or the Hospitals Act, regarding inquests following untoward hospital deaths.

"As I advised you by telephone a few days ago, there are no regulations under The Coroners Act. There is no provincial statute that I know of entitled The Hospitals Act. I take it you are referring to The Hospital Aid Act. If this is the statute you are referring to, there are no regulations under it dealing with inquests.

"Dr. Fryer, the Provincial Coroner, advises me that under an arrangement now in existence between the hospitals and himself, any sudden death in the hospital occurring within forty-eight hours of admission is reported to him and after consultation with the hospital authorities, he decides whether an inquest will be held. I understand in each such death an autopsy is ordered.

"A death ensuing after forty-eight hours of admission in which the attending physician will not sign a death certificate is reported to the

Provincial Coroner. If, however, the attending physician signs the death certificate, the death is not reported to the Coroner."

The Registrar was instructed to write to the Honourary Attending Staff of the Winnipeg General Hospital advising of the report he had received from the Department of the Attorney-General.

(f) Complaint Re Dr. _____

Letter From Mr. _____

The Council agreed to postpone consideration of this matter until item 4H of the agenda.

**(g) Meeting of Registrars at Vancouver
in June, 1954**

At the meeting of the Executive Committee held March 4th, the Registrar was given authority to attend the meeting of the Registrars to be held in Vancouver in June, the expenses to be paid by the College.

The Registrar presented the tentative agenda which outlined the subjects for discussion at the Registrars' meeting.

(h) Gordon Bell Memorial Fellowship

The Council agreed to postpone consideration of this matter until item 5B of the agenda.

(i) Communication From Grace Hospital

At the meeting of the Executive Committee held March 4th, a communication from Grace Hospital was considered, in which approval for internships for D.P. doctors who wish to write the Dominion Council examinations was requested. A motion was passed that the College inquire, on the basis of the communication from Grace Hospital, whether the Faculty of Medicine of the University of Manitoba would consider the formation of a joint committee to assess hospitals suitable for interne training.

The Registrar presented a communication from the Dean of the Faculty of Medicine, advising that two years ago a Committee of the Faculty, under the chairmanship of Dr. A. T. Mathers, was set up to assess hospitals for undergraduate internship. A questionnaire was sent out to several hospitals, including Grace, and the data has been under study for some time. The Dean suggested that if it is desired to have a joint committee set up, that the Faculty should be represented by Dr. Mathers or someone on his committee whom he might designate.

Motion: "THAT the Registration Committee consult with the Committee of the Faculty of Medicine concerning approval of hospitals for internship." Carried.

B. Registration Committee

The Chairman advised that seven meetings of the Registration Committee had been held since the Annual Meeting of Council held October 17th. He stated that the only matter for discussion was correspondence with the Command Medical Officer, Prairie Command, re licensing of Medical

Officers stationed in Manitoba, in which he suggests that the initial fee for such licences should be Ten Dollars (\$10.00) which is recoverable from the Department of National Defence. Temporary licence on payment of the annual fee only has been granted to officers in good standing in another Province. He suggested that approval of this action could be postponed until consideration of the amended By-laws.

C. Education Committee

The Chairman advised no meeting of the Education Committee had been held since the Annual Meeting of Council.

D. Finance Committee

The only matter requiring attention of this committee has been purchase of bonds which was fully discussed and authority given at last Council meeting. Consequently there has not been a meeting of the committee.

Respectfully submitted,

T. H. Williams, M.D., C.M.

Motion: "THAT the report of the Finance Committee be adopted." Carried.

E. Legislative Committee

Motion: "THAT the Council go into a Committee as a Whole to discuss the amended By-laws, Rules and Regulations." Carried.

The Committee rose, and the report will be considered under Item 10 of the agenda.

Following a brief adjournment for refreshments, the President, Dr. T. W. Shaw, requested the Vice-President, Dr. C. H. A. Walton, to remain in the Chair for the balance of the meeting.

F. Library Committee Representative

There have been three meetings of the Library Committee since our last meeting at which matters of staff were discussed and selection for purchase of books and periodicals decided.

An arrangement has been completed whereby photostat copies of pages of books or periodicals is now available on physicians' request. The price is 60c for the first 5 consecutive pages and 50c for each additional 10 or less consecutive pages. Last year rural loan requests of articles totalled over 2,000 pages. This photostat arrangement is much more satisfactory and gives permanent possession of the article copy while leaving the book or periodical available to others.

Expansion of the reading room facilities for students and graduates has been arranged. Book use has greatly increased.

An agency handling the purchase for physicians and students of medical or related books has been established as a book room in the Medical College.

The C.P. & S. has made the usual grant of \$750.00 to the Library. Two sizeable bequests to the library have been received.

Respectfully submitted,

T. H. Williams, M.D., C.M.

Motion: "THAT the report of the Library Committee Representative be adopted." Carried.

G. Discipline Committee

The Chairman reported that a letter had been received by the Registrar from the Chief of the Division of Narcotic Control, concerning a member of the College who had been placed on the confidential restricted list. No action was taken since the member moved to another Province.

Motion: "THAT the report of the Discipline Committee be adopted." Carried.

H. Taxing Committee

The Chairman outlined the circumstances concerning the Unsatisfied Judgment claim against Dr. At the meeting of the Executive Committee on March 4th, it was agreed that the matter be referred to the Taxing Committee and that Dr. prepare an itemized statement of his charges and appear before the Committee. The Taxing Committee interviewed Dr. on March 15th, and after careful consideration of the facts, were of the opinion that he fulfilled his duties in creditable manner, and the children's survival may have been due in large measure to the conscientious manner in which the first day's treatment was carried out. They agreed that Dr. charges should be reduced to \$500.00, and both the Court and the doctor have been notified.

Motion: "THAT the report of the Discipline Committee be adopted." Carried.

5. Reports of Special Committees and Their Consideration.

A. Representatives to the Manitoba Medical Association Executive

Dr. Ed. Johnson advised he and Dr. C. B. Stewart had attended most of the meetings of the Manitoba Medical Association Executive but had no problems to report.

B. Trustees of the Gordon Bell Memorial Fund

The Registrar read the following report of the Trustees as submitted by the Chairman.

It was moved by Dr. Lederman, seconded by Dr. Williams and approved that the following recommendation be forwarded to Council:

Motion: "THAT the sum of One Hundred Dollars monthly be granted to Doctor for the period of one year, beginning July 1, 1954."

Motion: "THAT the report of the Trustees of the Gordon Bell Memorial Fund be adopted, and that approval be given to the action of the Trustees in granting One Hundred (\$100.00) monthly to Dr. for one year, beginning July 1, 1954." Carried.

C. Representatives to the Committee of Fifteen

Dr. W. J. Boyd reported there had been no meetings of the Committee of Fifteen held since the October meeting of Council.

D. Representative to the Committee of Selection in Medicine

This committee does not meet until after students' marks for this year's entrance examinations and applications to enter the course are received.

Consequently there has not yet been a meeting.

Respectfully submitted,

T. H. Williams, M.D., C.M.

Motion: "THAT the report of the representative to the Committee of Selection in Medicine be adopted." Carried.

E. Representatives to the Medical Council of Canada

Dr. C. E. Corrigan advised that this had been discussed under Item 4A (d) on the agenda, and that he understood that the Medical Council of Canada will enforce the internship clause. He stated that the Council meets in September, and if any members had problems they wished brought up at that time, they should communicate with the Registrar's office.

Motion: "THAT the report of the representatives to the Medical Council of Canada be adopted." Carried.

F. Representative to the University Senate

No report.

G. Representatives to the Cancer Institute

Dr. M. T. Macfarland advised there had been a meeting of the Board of Trustees on March 31st. Dr. _____ contract was approved, and it was agreed that a Cobalt Bomb be installed in the St. Boniface Hospital, rental will be charged the Institute by the Hospital for use of premises. Dr. _____ reported that the plant for making radon seeds is now non-operative, and Irradiated Cobalt may replace 400 K.V. X-ray Therapy. He also advised that the Annual Meeting of the Board of Directors would be held on May 28th.

H. Representatives to the Liaison Committee—M.M.A. & C.P. & S.

No report.

I. Representative to the Canadian Arthritis and Rheumatism Society (Manitoba Division)

Dr. A. P. Guttman advised that a joint meeting of the Directors and Medical Advisory Committee had been held April 30th. The C.A.R.S. has now been accepted as a member of the Community Chest as of July 1st. The budget was submitted for the six months ending December 31st, 1954, which was approved by the Community Chest, and further budget is being prepared and will be submitted for approval.

Motion: "THAT the report of the representative to the Canadian Arthritis and Rheumatism Society (Manitoba Division) be adopted." Carried.

J. Representatives to the Specialist Committee

The Specialist Committee held its fifth and final meeting on the seventh of January, 1954. Nine applications for specialist registration were

deferred pending qualification by Royal College examination. Two applications were refused for inadequate qualification. Nine names were added to the Register.

Council is reminded that future applications for registration on the Specialist Register which are not covered by certification or fellowship in the Royal Colleges of Canada must be brought before this Council for action.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

The Registrar submitted applications for entry on the C.P. & S. Specialist Register from doctors who have not Royal College standing.

(a) _____

Dr. _____ is restricting his practice to Ophthalmology. He received his M.D., University of Manitoba, 1950, and L.M.C.C. the same year. From June to October, 1950, he studied Ophthalmology at Deer Lodge Hospital, and from January, 1951, to April, 1954, studied Ophthalmology at the Mayo Clinic and Foundation. He is completing requirements for the M.Sc. degree in Ophthalmology of the University of Minnesota Graduate School of Medicine. He has passed the written examination, his thesis has been approved, and he will be taking the oral examinations this month. He had also successfully taken the written portion of the examination of the American Board of Ophthalmology, and will be taking the final oral examination in June. He will be taking the certification examination of the R.C.P.S. of Canada this year, and has been granted major privileges in Ophthalmology at St. Boniface Hospital.

Motion: "THAT _____ application be deferred until he has written the R.C.P.S. (C) examinations." Carried.

(b) _____

Dr. _____ is restricting his practice to Otolaryngology. He received his M.D., University of Manitoba, 1950, and L.M.C.C. the same year. He completed a one year basic science course in Otolaryngology at the Post-graduate School, New York University, and two years Residency at New York University, Bellevue Medical Centre. He received his M.Sc., Otolaryngology, New York University, Bellevue Medical Centre, 1953, and expects to write his certification and American Board in E.N.T. in the Fall of 1954.

Motion: "THAT _____ application be deferred until he has written the R.C.P.S. (C) examinations." Carried.

(c) _____

Dr. _____ will be arriving to be employed at the Winnipeg Clinic in June, and will be restricting his practice to Obstetrics and Gynaecology. He received the degree M.B., B.Ch., Queen's University of Belfast, 1943. He also has the qualifications D.Obst. R.C.O.G., 1948; and M.R.C.O.G., 1950. Dr. _____ application for registration has

not yet been considered by the Registration Committee, and Council agreed his specialist application should be deferred until he is registered.

(d) _____

Dr. _____ is restricting his practice to Anaesthesia. He received the degree M.B., Ch.B., University of Birmingham. 1941; and his D.A., R.C.P.S., England, 1948. He is employed as an Anaesthetist at the Children's Hospital.

Motion: "THAT _____ name be placed on the Specialist Register in Anaesthesia." Carried.

(e) _____

Dr. _____ is restricting his practice to Paediatrics. He received the degrees B.Sc., University of Manitoba, 1941; M.D., University of Manitoba, 1949, and L.M.C.C. the same year. 1949-1951 he spent in rural general practice; 1951 was Assistant Resident in Pathology, Deer Lodge Hospital, and 1952-1954 has been Assistant Resident, Chief Resident, and Director of Out Patient Department, Children's Hospital. After twelve months practice of paediatrics he will be allowed to sit for the certification examination of the Royal College in the Fall of 1955. He has been appointed to the paediatric staff of St. Boniface and Children's Hospitals.

Motion: "THAT _____ application be deferred until he has written the R.C.P.S. (C) examinations." Carried.

The Registrar was advised to use the decisions in numbers (a), (b), and (e), as a guide for further applicants in the same category. Dr. Walton suggested that it might be helpful to have the applications for specialist registration submitted to the Executive Committee to be gone over in detail, before being referred to Council for action.

Motion: "THAT applications for registration on the Specialist Register, from physicians not qualified by the R.C.P.S. (C), be considered by the Executive Committee, which will bring in recommendations to Council." Carried.

6. Election of Officers and Standing Committees.

Not applicable at this meeting.

Election of Special Committees

A. Representative to the University Senate

Motion: "THAT our representative to the University Senate be Dr. C. H. A. Walton." Carried.

7. Reading of Communications, Petitions, etc., To the Council.

A. Complaint Re Dr. _____

Correspondence was presented from Mr. _____ concerning complaint against Dr. _____. The first communication, dated November 4, 1953, was received from Oslo, Norway, and outlined an operation which he had undergone in May, 1939. The case was before the Court in January, 1943, but was dismissed. The Registrar replied that since the disability from which Mr. _____ was suffering dated to 1939, and that the case was

considered and dismissed by the Courts in January, 1943, that the matter must be considered closed as far as this body is concerned. A letter from Mr. _____ dated March 10, 1954, was received from Vancouver, outlining the expenses he had incurred in going to Norway for further treatment and suggesting that the Winnipeg doctors should reimburse him. He also enclosed a letter from the Department of Health and Welfare of British Columbia, and advising that it would appear that the matter should be dealt with by the C.P. & S. of Manitoba rather than the organization in B.C. The Registrar replied that the matter would be placed before the Council meeting in May.

Motion: "THAT the Registrar communicate with Mr. _____ referring him to the College letter under date November 10, 1953, and advising that no further action is indicated." Carried.

B. Communication From Grace Hospital Re Approval of the Hospital for Graduate Training in Obstetrics

For information, a communication under date March 24, 1954, from the Superintendent of Grace Hospital, was presented advising that the Royal College of Physicians and Surgeons of Canada had approved Grace Hospital for graduate training in Obstetrics.

C. Communications From Supreme Court of Ontario Re Royal Commissions on the Law of Insanity as a Defence in Criminal Cases, and on Criminal Law Relating to Criminal Sexual Psychopaths

Communications were presented from the Supreme Court of Ontario advising that Commissions had been appointed "to inquire into and report upon the question whether the criminal law of Canada relating to the defence of insanity should be amended in any respect and, if so, in what manner and to what extent," and "to inquire into and report upon the question whether the criminal law of Canada relating to criminal sexual psychopaths should be amended in any respect and, if so, in what manner and to what extent." The Commissions expect to sit in Winnipeg on or about the 31st of August next, and desires to hear representations from members of the medical profession in this Province on these subjects. Those intending to make representations should submit a summary thereof in the form of a brief to the Secretary on or before the 15th of August.

Motion: "THAT the Council of the College of Physicians and Surgeons of Manitoba take note of the communications, and suggest that organized medicine, as represented by the Psychiatric Section of the Manitoba Medical Association, take the matter under immediate advisement. This Council expresses confidence in action which the Section of Psychiatry may take." Carried.

D. Request for Change of Name

The Registrar presented a communication from requesting to have her name changed on the records of the College to her married name A photostatic copy of her Certificate of Marriage under date April 15, 1954, was also presented.

changed to on the records of the College of Physicians and Surgeons of Manitoba." Carried.

E. Inquiries. None.**F. Notices of Motion. None.****G. Motions of Which Notice Has Been Given At Previous Meeting.**

The following Notice of Motion was given by Dr. W. J. Boyd at the Council meeting held October 17th, 1953:

"THAT the By-laws, Rules and Regulations of the College of Physicians and Surgeons of Manitoba be consolidated in conformity with the 1953 amendments to the Medical Act, and changes recommended to date by Council."

Dr. W. J. Boyd reported the action of the Committee of a whole.

Motion: "THAT the consolidated and revised By-laws, Rules and Regulations of the College of Physicians and Surgeons of Manitoba, as amended by the Committee of a whole be adopted by Council." Carried.

Motion: "THAT the By-laws, Rules and Regulations of the College of Physicians and Surgeons of Manitoba be printed." Carried.

H. Unfinished Business. None.**I. Miscellaneous and New Business.****A. Grant for Furnishing Medical College Auditorium**

The Treasurer advised that the Medical College is to be enlarged this year by the addition of a new wing. The amount of money available does not provide for the furnishing of an auditorium in the new building which would be very desirable to the medical profession as a whole. The Dean of the Faculty of Medicine has made a specific request that the College of Physicians and Surgeons of Manitoba entertain the furnishing of the auditorium which would be made available to the medical profession to hold medical meetings as required. Dr. Williams also suggested that a plaque be placed in the auditorium stating that the furnishings had been donated by the College.

Motion: "THAT the Council approves the furnishing of the auditorium in the new wing of the Medical College up to \$8,500.00, and the Executive Committee be authorized to proceed, in consultation with the Dean of the Faculty of Medicine, to take whatever steps required." Carried.

The Treasurer suggested raising the \$8,500.00 by taking \$1,000.00 from the Investment Trust Account, \$2,000.00 from the Current Account, and selling a \$500.00 1957 bond maturing in October, and a \$5,000.00 1959 bond now selling at a premium.

B. Appointment of Additional Alternate Scrutineers

Motion: "THAT Dr. Murray Campbell be appointed as alternate scrutineer for the election this summer." Carried.

"THAT Dr. L. A. Sigurdson be appointed alternate scrutineer for the election this summer." Carried.

"THAT nominations be closed." Carried.

C. Amount to be Paid to Council Members for This Meeting

Motion: "THAT the amounts paid to members of the Council for attendance at this meeting be the usual rate in accordance with the new By-laws." Carried.

D. Date of Next Council Meeting

Motion: "That the Annual Meeting of Council be held at 9 a.m., Central Standard Time, on Saturday, October 16th, 1954." Carried

E. Acknowledgment to Manitoba Medical Service

It was agreed that a letter of thanks be forwarded to the Manitoba Medical Service for the general invitation for the use of the Board Room for C.P. & S. meetings, and also to the Executive Director for his co-operation.

F. Vacations

The Registrar reported that Miss Allison would be taking her holidays during the month of June, when she is to be married, and Miss Zawadzki during the month of August.

G. Adjournment

The meeting adjourned at 12.30 p.m., D.S.T.

Registration Committee

June 2, 1954

Enabling Certificate Deferred

Woldemar Artes—M.D., Stalin Medical Institute, 1936.

Certificate of Registration Deferred

George Mair Arnott—M.B., Ch.B., U. Glasgow, 1936; F.R.C.S., Edinburgh, 1939.

Edward Millar Wilson Stuart—M.B., B.Ch., Queen's U. of Belfast, 1952.

Certificates of Registration Confirmed

Thomas Noel Ferguson Todd—M.B., B.Ch., Queen's U. of Belfast, 1949.

Eric Milne—M.B., Ch.B., U. Aberdeen, 1939.

Certificate of Registration Granted

Thomas Mervyn Roulston—M.B., B.Ch., Queen's U. of Belfast, 1943; D. Obst. R.C.O.G., 1948; M.R.C.O.G., 1950.

Certificates of Licence (Temporary)—?**Documentation Fee**

Motion: "THAT Part 9, Paragraph 2, of the amended By-laws, Rules and Regulations, be interpreted to mean that the Documentation Fee will not be collected from applicants for Certificate of Licence (temporary), unless otherwise directed by the Committee, this motion to be ratified by the next meeting of Council." Carried.

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Licensed Practitioners

The Committee reviewed the correspondence which the Registrar has had with three persons suspected of practising medicine contrary to the Medical Act.

Registration Committee

July 21, 1954

Enabling Certificates Deferred

Alexander Johannes Bozyk—M.D., U. Vienna, 1944.

Elvira Lili Kukuk—M.D., U. Jena, 1949.

Jan Wolter Oosterhuis—M.D., U. Groningen, 1951.

Edward Wolak—M.D., U. Jagiellonski, Krakow, 1940.

Edward Schludermann—M.D., U. Vienna, 1932.

James Hingston—M.B., B.Ch., National U. of Ireland, 1944; M.D., National U. of Ireland, 1946; M.R.C.P., Irel., 1947; D.C.H., R.C.P.S., Irel., 1947; M.R.C.P., Edinburgh, 1951.

Enabling Certificate Granted

Dennis Han-Chuen Lin—M.D., West China Union U., 1947.

Certificate of Registration Deferred

Ralph Fredman—L.R.C.P., Edin., 1941; L.R.C.S., Edin., 1941; L.R.F.P.S., Glasg., 1941.

Certificates of Registration Confirmed

George Mair Arnott—M.B., Ch.B., U. Glasgow, 1936; F.R.C.S., Edin., 1939.

Charles Ross Green—M.D., C.M., Queen's U., 1953; L.M.C.C., 1953.

Douglas Jamieson—M.B., Ch.B., U. Glasgow, 1942; F.R.F.P.S., Glasg., 1947; M.R.C.P., Lond., 1947; D.T.M. & H., U. Liverpool, 1949.

Ching Po Yang—M.D., Peiping Union Medical College, 1931; L.M.C.C., 1954.

Pieter de Jong—M.D., U. Leiden, 1950; L.M.C.C., 1954.

Howard Alan Guest—M.D., C.M., Queen's U., 1953; L.M.C.C., 1953.

Certificates of Registration Granted

Kenneth Yu-mien Hsu — M.D., St. John's U., Shanghai, 1942; L.M.C.C., 1954.

James Elton Gilbert—M.R.C.S., England, 1941; L.R.C.P., London, 1941.

John Edward Leslie Bendor-Samuel—M.R.C.S., England, 1930; L.R.C.P., London, 1930; M.B., B.S., U. London, 1931; D.O.M.S., R.C.P.S., England, 1946.

James Desmond McDowell—M.B., B.Ch., Queen's U. of Belfast, 1948.

James Huggan Scott—M.B., Ch.B., U. Edinburgh, 1944; D.O., R.C.P.S., England, 1950.

Norman Dryburgh McCreath—M.B., Ch.B., U. New Zealand, 1939; M.R.A.C.P., 1946; M.R.C.P., London, 1949.

Certificates of Licence (Temporary) Confirmed

Roman Buczok—M.D., U. Madrid, 1951; L.M.C.C., 1954.

William Alexander Robb—M.D., U. Western Ontario, 1943; L.M.C.C., 1943.

Certificate of Licence (Temporary) Granted

Clifford John Olson—M.D., U. Western Ontario, 1953; L.M.C.C., 1953.



The seal of the College of Physicians and Surgeons of Manitoba indicates that incorporation was effected in 1877. Reproduced herewith is a letter received by Dr. R. B. Mitchell from Professor Wm. Hugill, Department of Classics, University of Manitoba, which offers a conjectural interpretation of the seal.

"With regard to the impression of the official seal of the College of Physicians and Surgeons of Manitoba which you have sent me, all that I can say from examining the features of the impression is that it seems reasonable to assume that the male figure is that of Apollo, the archer of the silver bow, the slayer of the dragon, Python, at Delphi.

This myth is based upon the historic fact that the prophetic cult of Apollo replaced an earlier cult at Delphi according to which the oracle was guarded by a dragon. The dragon and Apollo represent two stages in the history of the Delphic

Oracle and both are primarily associated with prophecy, not the healing art. This, I suppose, does not preclude the possibility that the College of Physicians and Surgeons of Manitoba may have used the dragon as a symbol of unlicensed quackery and the slaying of the dragon as a symbol of the establishment of a more enlightened control over the healing art.

Apollo, in Greek mythology, is often called by the epithets, "the healer," "the averter of evil," and he was also said to be the father of Asclepius, who in turn was the father of Hygieia and Panacea and several others.

Apollo was also thought to be the god of light and was often merged in identity with Helios, the Sun god. This might account for the rays of light which seem to emanate from the head of the figure in the impression.

The objects on either side of the figure of the god which resemble teepees are a complete mystery to me.

All that I have said is quite conjectural as applied to the impression of the seal. It is unfortunate that you have not been able to find any record of the original intention of the designer or of those who authorized the design. If you ever do, I shall be interested to learn of it."

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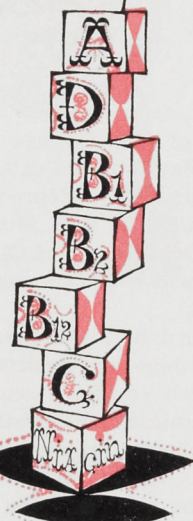
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CANADA



Department of Health and Public Welfare Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1954		1953		Total	
	Sept. 5 to Oct. 2, '54	Aug. 8 to Sept. 4, '54	Sept. 6 to Oct. 3, '53	Aug. 9 to Sept. 5, '53	Jan. 1 to Oct. 2, '54	Jan. 1 to Oct. 3, '53
Superior Poliomyelitis	8	30	464	853	108	2132
Chickenpox	72	42	40	33	1331	1004
Dysentery	0	0	0	0	0	4
Diarrhoea and Enteritis, under 1 yr.	10	8	16	34	119	166
Dysentery Carriers	0	0	0	0	0	0
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	2	0	2	5	19	16
Dysentery—Bacillary Carrier	0	0	0	0	1	0
Epidemic Typhus	3	1	1	4	23	27
Epidemic Paratyphoid	3	1	3	4	4	11
Influenza	6	6	6	10	70	214
Measles	32	73	11	25	859	2285
Measles—German	0	1	0	0	14	39
Meningococcal Meningitis	2	1	1	1	16	28
Rabies	24	31	26	32	943	865
Ophthalmia Neonatorum	0	0	0	0	0	0
Scarlet Fever	0	0	0	0	0	1
Scarlet Fever	23	7	19	10	422	310
Strep. Sore Throat	0	4	7	3	44	83
Smallpox	0	0	0	0	0	0
Scarlet	0	0	0	1	2	2
Cholera	0	0	0	0	0	0
Tuberculosis	56	87	53	48	506	755
Typhoid Fever	0	0	0	0	3	0
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	0	0	0	0	0	0
Typhoid Carrier	0	1	1	0	5	10
Whooping Cough	39	21	22	22	105	167
Norrhoea	103	113	128	130	1024	950
Syphilis	6	11	5	4	81	65
Infectious Jaundice	14	10	21	29	267	258
Leukemia	1	0	0	0	2	2

our-week Period, September 5th to October 2nd, 1954

DEATHS FROM REPORTABLE DISEASES

September, 1954

DISEASES	*809,000 Manitoba	*861,000 Saskatchewan	*3,825,000 †Ontario	*2,952,000 Minnesota
(White Cases Only)				
Approximate population.				
Superior Poliomyelitis	8	28	34	203
Chickenpox	72	16	122	---
Diarrhoea and Enteritis, Under 1 Year	10	35	---	---
Dysentery	---	2	1	---
Dysentery Carriers	---	---	---	5
Dysentery—Amoebic	---	---	---	11
Dysentery—Bacillary	2	1	9	---
Epidemic Typhus	3	4	---	---
Epidemic Paratyphoid	3	1	---	---
Influenza	6	2	3	2
Measles, Infectious	14	40	74	105
Measles	---	1	---	---
Measles	32	7	97	33
German Measles	---	8	30	---
Meningitis Meningococcus	2	2	3	5
Rabies	24	31	163	---
Ophthalm. Neonat.	---	---	---	---
Scarlet Fever	---	---	---	---
Scarlet Fever	23	8	47	9
Strep. Sore Throat	---	30	14	54
Smallpox	---	---	---	---
Scarlet	---	---	---	---
Cholera	---	---	---	---
Tuberculosis	56	60	34	114
Leukemia	1	---	---	1
Typhoid Fever	---	2	14	---
Ph. Para-Typhoid	---	1	2	---
Typhoid Carriers	---	---	---	---
Typhoid Carrier	---	---	1	11
Whooping Cough	39	18	523	101
Norrhoea	103	---	169	---
Syphilis	6	---	48	---

†Only 3 weeks, fourth report not received at date of filing.

Urban—Cancer, 62; Pneumonia (other forms), 7; Syphilis, 2; Tuberculosis, 4; Streptococcal Sore Throat, 1; Septicaemia and Pyaemia, 1; Other infective and parasitic diseases, 1; Meningococcal infections, 1; Late effects of acute infectious encephalitis, 1. Other deaths under 1 year, 20. Other deaths over 1 year, 155. Stillbirths, 17. Total, 192.

Rural—Cancer, 41; Pneumonia, Lobar (490), 1; Pneumonia (other forms), 4; Tuberculosis, 1; Diarrhoea and Enteritis, 3. Other deaths under 1 year, 10. Other deaths over 1 year, 159. Stillbirths, 13. Total, 182.

Indians—Cancer, 1; Pneumonia (other forms), 1; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 1. Other deaths over 1 year, 10. Total, 11.

Chickenpox and **Whooping Cough** are both on the increase at the present time. Immunization against whooping cough is well worthwhile in the younger age groups and every baby should be protected unless he suffers from skin rash or allergy.

Scarlet Fever also shows an increase this year but it is only a shadow of what is was thirty years ago.

Poliomyelitis—Always an enemy but in 1954 a weak one!

Veneral Disease—Much the same as last year and we must find and treat all cases to render them non-infectious. Education is most important.

Northwestern District Medical Society

A meeting of the Northwestern District Medical Society was held at the Municipal Hall, Hamiota, on Thursday, September 23rd. Present were:

Doctors J. B. Baker, Brandon; S. E. Bjornson, Miniota; J. S. Brown, Brandon; A. J. Elliott, Oak River; W. A. Gorrie, Virden; W. K. Hames, Kenton; W. P. Hirsch, Brandon; E. D. Hudson, Hamiota; J. E. Hudson, Hamiota; Donna Huggins, Winnipeg; M. T. Macfarland, Winnipeg; J. C. MacMaster, Winnipeg; R. F. M. Myers, Brandon; A. P. Lapko, Brandon; F. K. Purdie, Griswold; J. E. Rowlands, Brandon; W. J. Sharman, Clanwilliam; V. J. H. Sharpe, Brandon; T. W. Shaw, Russell; H. C. Stevenson, Minnedosa; W. F. Tisdale, Winnipeg; G. I. Wortzman, Rivers.

Dinner was served under the direction of the Women's Institute and was followed by brief speeches by Dr. W. F. Tisdale, President, Manitoba Medical Association, and Dr. E. D. Hudson, veteran member of the Society.

The business session was conducted by Dr. J. E. Hudson, following which Dr. Donna Huggins, Winnipeg, delivered a paper on "Recent Advances in Anaesthesia," illustrated by slides. Dr. J. C. MacMaster discussed Manitoba Medical Service and the term insurance which is being arranged for medical members.

Following the meeting, members and their wives were entertained at coffee by Doctor and Mrs. E. D. Hudson.

Book Review

Child Birth Made Easier by the Mother Herself is the interesting and challenging title of a thirteen-page pamphlet. Its purpose is to impress upon the prospective mother that having a baby is a perfectly natural thing, that no labours are completely painless but that the ability to relax and to change fear to pleasant anticipation, can make the process very much easier. About half the pamphlet is devoted to a series of simple exercises simply illustrated. The rest consists of an outline of the process of labour and how the mother can reduce the discomforts of each stage. The instructions are brief, simple and easy to understand. The author—Irene E. Dickie—is a physiotherapist attached to the University of Saskatchewan, and there is a Foreword by the Dean of Medicine. Single copies cost 50 cents, twenty-five or more cost twenty cents each. Burns and MacEachern, 12 Grenville St., Toronto 2, Ont.

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